

LAW
KF
3643
U5
1967h
pt.2



H-11111 43167
H-min 6/7/67

PRESIDENT'S PROPOSALS FOR REVISION IN THE SOCIAL SECURITY SYSTEM

CH

HEARINGS BEFORE THE COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES

NINETIETH CONGRESS

FIRST SESSION

ON

H.R. 5710

TO AMEND THE SOCIAL SECURITY ACT TO PROVIDE AN INCREASE IN BENEFITS UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, TO PROVIDE BENEFITS FOR ADDITIONAL CATEGORIES OF INDIVIDUALS, TO PROVIDE HEALTH INSURANCE TO THE DISABLED, TO IMPROVE THE PUBLIC ASSISTANCE PROGRAM AND PROGRAMS RELATING TO THE WELFARE AND HEALTH OF CHILDREN, TO REVISE THE INCOME TAX TREATMENT OF THE AGED, AND FOR OTHER PURPOSES

MARCH 1, 2, 3, 6, 7, 8, 9, 10, 13, 16, 20, 21, 22, 23,
APRIL 4, 5, 6, AND 11, 1967

Part 2

CONTAINS MARCH 6, 7, 8, 9, 10, 13, AND 16, 1967

Printed for the use of the Committee on Ways and Means



Information
Resource
Center

LAW 13.8

PRESIDENT'S PROPOSALS FOR REVISION IN THE SOCIAL SECURITY SYSTEM

KF
3643
-45
1967h
pt.2

HEARINGS BEFORE THE COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES NINETIETH CONGRESS FIRST SESSION

ON

H.R. 5710

TO AMEND THE SOCIAL SECURITY ACT TO PROVIDE AN INCREASE IN BENEFITS UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, TO PROVIDE BENEFITS FOR ADDITIONAL CATEGORIES OF INDIVIDUALS, TO PROVIDE HEALTH INSURANCE TO THE DISABLED, TO IMPROVE THE PUBLIC ASSISTANCE PROGRAM AND PROGRAMS RELATING TO THE WELFARE AND HEALTH OF CHILDREN, TO REVISE THE INCOME TAX TREATMENT OF THE AGED, AND FOR OTHER PURPOSES

MARCH 1, 2, 3, 6, 7, 8, 9, 10, 13, 16, 20, 21, 22, 23,
APRIL 4, 5, 6, AND 11, 1967

Part 2

CONTAINS MARCH 6, 7, 8, 9, 10, 13, AND 16, 1967

Printed for the use of the Committee on Ways and Means



CMS Library
02-07-13
7500 Security Blvd.
Baltimore, MD 21244

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1967

75-833 O

COMMITTEE ON WAYS AND MEANS

WILBUR D. MILLS, Arkansas, *Chairman*

CECIL R. KING, California
HALE BOGGS, Louisiana
FRANK M. KARSTEN, Missouri
A. S. HERLONG, Jr., Florida
JOHN C. WATTS, Kentucky
AL ULLMAN, Oregon
JAMES A. BURKE, Massachusetts
MARTHA W. GRIFFITHS, Michigan
GEORGE M. RHODES, Pennsylvania
DAN ROSTENKOWSKI, Illinois
PHIL M. LANDRUM, Georgia
CHARLES A. VANIK, Ohio
RICHARD H. FULTON, Tennessee
JACOB H. GILBERT, New York

JOHN W. BYRNES, Wisconsin
THOMAS B. CURTIS, Missouri
JAMES B. UTT, California
JACKSON E. BETTS, Ohio
HERMAN T. SCHNEEBELI, Pennsylvania
HAROLD R. COLLIER, Illinois
JOEL T. BROYHILL, Virginia
JAMES F. BATTIN, Montana
BARBER B. CONABLE, Jr., New York
GEORGE BUSH, Texas

WILLIAM H. QUEALY,
Minority Counsel

LEO H. IRWIN, *Chief Counsel*

JOHN M. MARTIN, Jr., *Assistant Chief Counsel*

CONTENTS

PART 1

1967:	Page
Wednesday, March 1	1-238
Thursday, March 2	239-350
Friday, March 3	351-445

PART 2

Monday, March 6	447-558
Tuesday, March 7	559-685
Wednesday, March 8	687-786
Thursday, March 9	787-936
Friday, March 10	937-1060
Monday, March 13	1061-1154
Thursday, March 16	1155-1196

PART 3

Monday, March 20	1197-1266
Tuesday, March 21	1267-1408
Wednesday, March 22	1409-1549
Thursday, March 23	1551-1643
Tuesday, April 4	1645-1766
Wednesday, April 5	1767-1892

PART 4

Thursday, April 6	1893-1925
Tuesday, April 11	1927-2066
Material submitted for the record	2067-2452

Message from the President of the United States entitled "Aid for the Aged" (H. Doc. 40, 90th Cong., 1st sess.)	3
Message from the President of the United States entitled "Welfare of Children" (H. Doc. 54, 90th Cong., 1st sess.)	11
Press release dated Wednesday, February 15, 1967, announcing public hearings on President's proposals for revisions in the social security system	25
Text of H.R. 5710, "Social Security Amendments of 1967"	26
Section-by-section analysis and explanation of provisions of H.R. 5710, the "Social Security Amendments of 1967" (committee print)	79

STATEMENTS BY GOVERNMENT OFFICIALS

Civil Service Commission, Hon. John W. Macy, Jr., Chairman	447
Health, Education, and Welfare, Department of:	
Ball, Hon. Robert M., Commissioner of Social Security	217, 239, 351
Cohen, Hon. Wilbur J., Under Secretary	239, 351
Gardner, Hon. John W., Secretary	128, 239, 351
Lee, Hon. Philip R., Assistant Secretary (Health and Scientific Affairs)	351
Myers, Robert J., Chief Actuary, Social Security Administration	239, 351
Winston, Dr. Ellen, Commissioner of Welfare	351
Treasury, Department of, Hon. Stanley S. Surrey, Assistant Secretary of the Treasury for Tax Policy	195, 351

MATERIAL SUBMITTED FOR THE RECORD BY GOVERNMENT OFFICIALS

	Page
Ball, Hon. Robert M., Commissioner of Social Security, Social Security Administration, Department of Health, Education, and Welfare:	
Chart 1—Major proposals for improvements in the social security program.....	217
Chart 2—Higher benefits for over 23 million beneficiaries.....	218
Chart 3—Increased social security protection for nearly all workers and their families.....	218
Chart 4—At least a 15-percent increase with a minimum benefit of \$70.....	219
Chart 5—Present and proposed contribution rates for cash benefits.....	220
Chart 6—The maximum contribution and benefit base under present law and under proposal.....	221
Chart 7—Comparison of monthly benefits for workers.....	222
Chart 8—Replacement of preretirement earnings for a worker age 65.....	223
Chart 9—Replacement of preretirement earnings for a couple age 65.....	224
Chart 10—Monthly contributions and cash benefits for average monthly earnings of \$550 and below.....	224
Chart 11—Monthly contributions and cash benefits for average monthly earnings of \$550 and above.....	225
Chart 12—Special payments to people age 72 or older.....	227
Chart 13—A special minimum benefit for workers with long-term coverage.....	228
Chart 14—Increase in the amount a beneficiary can earn and still get benefits.....	229
Chart 15—Number of people affected by retirement test.....	229
Chart 16—Benefits for disabled widows.....	231
Chart 17—Transfer of credits for Federal employment to social security.....	232
Chart 18—Improved social security coverage for 500,000 farm employees.....	233
Chart 19—Financing social security cash benefits.....	234
Chart 20—Estimated progress of the cash-benefits trust funds under present law and under proposal, 1967-70.....	235
Chart 21—Extension of hospital insurance protection and medical insurance protection.....	236
Chart 22—Other medicare proposals.....	237
Chart 23—Total social security benefit payments in 1968.....	238
Child benefits, where placed with a family for adoption before the worker's death but not actually adopted until more than 2 years after the worker's death.....	240
Comments on testimony by representatives of National Association of Blue Shield Plans and commercial insurance organizations, serving as carriers for supplementary medical insurance under title XVIII.....	549
Contribution and benefit bases and contribution rate schedules under legislation enacted 1935-65.....	259
Contribution rates and contribution rates actually in effect through 1967, and scheduled in present law for the future.....	260
Employer social security costs under 1935 act, under present law, and under H.R. 5710 with table entitled "Comparison of ultimate social insurance costs for special security and unemployment insurance, before and after corporation income taxes applied at the maximum, minimum, and average rates, as a percent of total payroll".....	260
Letter dated April 27, 1967, to John M. Martin, Jr., assistant chief counsel, Ways and Means Committee, with 2 enclosures.....	1108
Report regarding the coverage of eye care under the health insurance program (by HEW, Social Security Administration).....	1109
A position statement by the American Optometric Association's department of national affairs concerning title XVIII of Public Law 89-97.....	1111
Medicare part C proposal, questions and answers on the effect of.....	291
Outpatient hospital and diagnostic specialty benefits for the aged and disabled—proposed part C.....	290

	Page
Ball, Hon. Robert M., etc.—Continued	
Poverty and social security benefits (from the Research and Statistics Note of February 24, 1967).....	302
Table 1—OASDHI and estimated poverty and low-income status of persons aged 65 and over as of July 1, 1967.....	307
Table 2—Estimated amount and percent of benefits going to poor and low-income beneficiaries aged 65 and over, fiscal 1968 (present law).....	307
Table 3—Aged OASDI beneficiaries: Estimated poverty and low-income status as of July 1, 1967, under present law and specified benefit-increases.....	308
Table 4—All persons aged 65 and over: Estimated poverty and low-income status as of July 1, 1967, under present law and specified benefit increases.....	309
Table 5—Effect of specified benefit increases on estimated poverty and low-income status of persons aged 65 and over as of July 1, 1967.....	310
Table 6—All OASDI beneficiaries: Estimated poverty status as of July 1, 1967, under present law and specified benefit increases.....	310
Cohen, Hon. Wilbur J., Under Secretary, Department of Health, Education, and Welfare:	
Comparison of certain sections of H.R. 5710 with present law and H.R. 18225, 89th Cong.....	324
Letter dated January 16, 1967, to Hon. John Gardner, Secretary, Health, Education, and Welfare, from John K. Pickens, general counsel, American Nursing Home Association.....	355
Letter dated February 25, 1967, to John K. Pickens, general counsel, American Nursing Home Association, from Wilbur J. Cohen, Under Secretary of Department of Health, Education, and Welfare.....	355
Letter dated April 6, 1967, to Chairman Mills.....	1397
Minimum social security benefit, a study of people who are receiving it.....	313
Old-age assistance—Percent that amount paid for basic needs for an aged woman represents of total monthly cost standard for basic needs of such recipient by State, January 1967.....	268
Poverty index of the Social Security Administration, description of.....	425
Public and private pensions, relative roles.....	401
Growth in employee-benefit plans, 1950–65.....	403
Table 1—Estimated number of wage and salary workers and their dependents covered under employee-benefit plans, by type of benefit.....	418
Table 2—Estimated total employer and employee contributions under employee-benefit plans, by type of benefit, 1950, 1955, 1960–65.....	420
Table 3—Estimated benefits paid under employee-benefit plans, by type of benefit, 1950, 1955, 1960–65.....	421
Table 4—Coverage and contributions under employee-benefit plans, by type of benefit, in relation to employed wage and salary labor force and payroll, 1950, 1955, 1960–65.....	422
Table 5—Private pension and deferred profit-sharing plans; estimated overage, contributions, beneficiaries, benefit payments, and reserves, 1950, 1955, 1960–65.....	423
Public assistance—Estimated annual reduction in expenditures for public assistance from Federal and non-Federal funds as a result of title I of H.R. 5710, Social Security Amendment of 1967.....	347
Retirement test under the social security program.....	316
Appendix I—Comparison of the amount of earnings a beneficiary can have before all benefits are withheld under the retirement test provisions in present law and under those in H.R. 5710.....	319
Appendix II—Applicability of the retirement test with respect to people aged 65 and over eligible for social security benefits, by estimated amount of earnings in 1967.....	319
Skilled nursing homes, policies regarding, letter dated March 4, 1967, from Hon. Wilbur J. Cohen, Under Secretary of HEW.....	361

	Page
Comptroller General of the United States, report to Subcommittee on Long-Term Care, Special Committee on Aging, U.S. Senate.....	873
Gardner, Hon. John W., Secretary, Department of Health, Education, and Welfare:	
Actuarial soundness of the OASDI program.....	342
Advisory Council statements concerning the financial soundness of the social security program.....	342
Long-range cost estimates for old-age, survivors, and disability insurance system, 1966—Actuarial Study No. 63, January 1967, published by Social Security Administration, HEW.....	331
Value of social security protection in relation to the value of social security contribution.....	330
Work experience and training program under title V of the Economic Opportunity Act.....	366
Young worker analysis of whether he receives his money's worth under social security with tables showing benefit protection and monthly contributions of covered workers at selected ages and earnings levels.....	331
Macy, Hon. John W., Jr., Chairman, U.S. Civil Service Commission, report on H.R. 5710.....	447
Myers, Robert J., Chief Actuary, Social Security Administration, Department of Health, Education, and Welfare:	
Actuarial cost data for 1967 legislative proposal to modify OASDHI system.....	282
Table 1—Increases in level cost for OASDI system under H.R. 5710, by type of change.....	284
Table 2—Increases in level cost for HI system under H.R. 5710, by type of change.....	284
Table 3—Estimated progress of OASL, disability insurance, and hospital insurance trust funds under present law.....	285
Table 4—Estimated progress of OASI, disability insurance, and hospital insurance trust funds under H.R. 5710.....	285
Actuarial cost data on medicare aspects of H.R. 5710.....	281
Increased benefits, present value of, under H.R. 5710.....	263
Table 1—Tax rate, tax base, and tax amount applicable to employers and employees (each) under present law and under H.R. 5710, old-age, survivors, and disability insurance program, 1967–87 and after.....	255
Table 2—Tax rate, tax base, and tax amount applicable to self-employed persons under present law and under H.R. 5710, old-age, survivors, and disability insurance program, 1967–87 and after.....	255
Table 3—Tax rate, tax base, and tax amount applicable to employers, employees, and self-employed persons under present law and under H.R. 5710, basic hospital insurance program, 1967–87 and after.....	256
Table 4—Estimated aggregate taxes on employers, employees, and self-employed persons under present law and under H.R. 5710, old-age, survivors, and disability insurance program, 1967–70, 1975, 1980, 1985, and 1990.....	256
Table 5—Combined tax rate on employer and employee under present law and under H.R. 5710, old-age, survivors, and disability insurance program and basic hospital insurance program, 1967–87 and after.....	257
Table 6—Combined tax on employer and employee under present law and under H.R. 5710, old-age, survivors, and disability insurance program and basic hospital insurance program, 1967–87 and after.....	257
Surrey, Hon. Stanley S., Assistant Secretary of the Treasury for Tax Policy, Department of the Treasury:	
Constitutionality of including retirement benefits of the Social Security and Railroad Retirement Systems in gross income (Opinion 789, Treasury Department, Office of the General Counsel).....	373
Exemptions, effect of increasing, in President's proposal to \$2,400 (single) and \$4,800 (married).....	398
Tax treatment of the aged, Title V of H.R. 5710.....	201

STATEMENT OF PUBLIC WITNESSES

	Page
Ackerman, Carl R., M.D., chairman, board of directors, National Association of Blue Shield Plans.....	529, 539
Adams, Hon. Brock, a Representative in Congress from the State of Washington.....	1170
Adam, Ludwig, Lenox Hill Neighborhood Association.....	1881
AFL-CIO, industrial union department, Leonard Lesser, general counsel.....	1420
Affiliated Government Organizations, Mrs. Rhoda A. Ruff, chairman.....	1619
Air Line Pilots Association:	
Meals, James, director, governmental and legislative affairs.....	1491
Nichols, Donald H., regional vice president.....	1491
Allied Pilots Association, Nicholas J. O'Connell, Jr., president.....	1499
Alvarez-De Choudens, Dr. J. A., president-elect, and Dr. Luis A. Izquierdo-Mora, president, Puerto Rico Medical Association.....	1630
American Academy of Pediatrics, Association of Medical School Pediatric Department Chairmen, American Pediatric Society, and Society for Pediatric Research, Dr. Ralph Wedgwood.....	1171
American Association of Bioanalysts, Bernard I. Diamond, chairman, government and professional relations council.....	1050
American Association of Homes for the Aging, Thomas M. Jenkins, president.....	1003
American Association of Retired Persons and National Retired Teachers Association, William C. Fitch, executive director.....	1247
American Chiropractic Association, Hon. Norman A. Erbe, executive director.....	982
Buchanan, Dr. Wallace D., past president.....	1796
Calhoun, Dr. Joseph D., chairman, board of chancellors.....	1796
American Council of the Blind, Durward McDaniel, legislative chairman.....	1999
American Dental Association:	
Conway, Bernard J., chief legal officer.....	1062
Ostrander, Dr. F. Darl, president-elect.....	1062
American Federation of Government Employees, Thomas G. Walters, legislative representative.....	1607
American Federation of Labor and Congress of Industrial Organizations (AFL-CIO):	
Meany, George, president.....	571
Seidman, Bert, director, social security department.....	571
American Federation of Teachers, Carl J. Megal, Washington representative.....	1483
American Hospital Association:	
Berke, Mark.....	714
Cartmill, George, president.....	687
Crosby, Dr. Edwin J., executive vice president.....	726
Eppert, Ray R.....	693
Freitag, William.....	687
Graham, Dr. George W.....	721
Mueller, William J.....	701
Williamson, Kenneth, associate director.....	735
American Insurance Association, Andrew Kalmykow, counsel.....	1244
American Life Convention and Life Insurance Association of America, George W. Young, chairman, joint social security committee.....	1210
American Medical Association:	
Harrison, Bernard, legislative department.....	1651
Hudson, Dr. Charles L., president.....	1651
Rouse, Dr. Milford O., president-elect.....	1651
American Medical Technologists, Ralph S. Haskins, national president.....	974
American Mutual Insurance Alliance, Wallace M. Smith, manager, mid-Atlantic office.....	1645
American Nursing Home Association:	
Morris, Stephen J.....	808
Pickens, John K., general counsel.....	787
Smith, Marvin.....	822
Walker, Edward, president.....	787
Wick, Charles Z.....	825

	Page
American Optometric Association, W. Judd Chapman, O.D., chairman, legislative committee-----	1091
American Parents Committee, Mrs. Barbara D. McGarry, executive director-----	2005
American Pediatric Society, Association of Medical School Pediatric Department Chairmen, American Academy of Pediatrics, and Society for Pediatric Research, Dr. Ralph Wedgwood-----	1171
American Podiatry Association, Dr. Douglas T. Mowbray, president-----	1137
American Psychiatric Association and National Association of Private Psychiatric Hospitals, Dr. Robert W. Gibson-----	1080
American Psychological Association, Dr. Arthur H. Brayfield, executive officer-----	1010
American Public Health Association, Dr. Milton Terris, president-----	1129
American Public Welfare Association, Wilbur J. Schmidt, chairman, national council of State public welfare administrators-----	831
American Society of Anesthesiologists, Dr. Perry P. Volpitto, past president-----	1809
Anderson, Hon. John B., a Representative in Congress from the State of Illinois-----	1769
Arkansas State Department of Public Welfare, A. J. Moss, commissioner-----	1788
Association of Medical School Pediatric Department Chairmen, American Academy of Pediatrics, American Pediatric Society, and Society for Pediatric Research, Dr. Ralph Wedgwood-----	1171
Beasley, Dr. Joseph, member of the board, Planned Parenthood-World Population-----	1508
Bennett, Hon. Charles E., a Representative in Congress from the State of Florida-----	1767
Berke, Mark, American Hospital Association-----	714
Berry, Hon. E. Y., a Representative in Congress from the State of South Dakota-----	1164
Biegalle, Murray L., National Conference of State Social Security Administrators-----	1482
Bingham, Hon. Jonathan B., a Representative in Congress from the State of New York-----	1902
Blechinger, Carl J., National Conference of State Social Security Administrators-----	1481
Blue Cross Association, Walter J. McNerney, president-----	477
Blue Shield Plans, National Association of: Ackerman, Carl R., M.D., chairman, board of directors-----	529, 539
McCabe, John C., president, Michigan Blue Shield-----	529, 534
Boland, Hon. Edward P., a Representative in Congress from the State of Massachusetts-----	1981
Brayfield, Dr. Arthur H., executive officer, American Psychological Association-----	1010
Buchanan, Dr. Wallace D., past president, American College of Radiology-----	1796
Burton, Hon. Phillip, a Representative in Congress from the State of California-----	1927
Calhoun, Dr. Joseph D., chairman, board of chancellors, American College of Radiology-----	1796
California Deans of Social Welfare and Social Work and the advisory committee on undergraduate education of the Council on Social Work Education, Ernest F. Witte-----	1921
Campbell, Dr. Colin D., Department of Economics, Dartmouth College-----	1388
Carey, Hon. Hugh L., a Representative in Congress from the State of New York-----	1912
Carstenson, Blue A., assistant legislative director, National Farmers Union-----	1294
Carter, Hon. Tim Lee, a Representative in Congress from the State of Kentucky-----	1983
Cartmill, George, president, American Hospital Association-----	687
Chamber of Commerce of the United States: Chase, Henry H., social security committee-----	1328
Egger, Roscoe L., Jr., taxation committee-----	1347
Chapman, W. Judd, O.D., chairman, legislative committee, American Optometric Association-----	1091
Chase, Henry H., social security committee, Chamber of Commerce of the United States-----	1328

	Page
Child Welfare League of America, Joseph H. Reid, executive director.....	1984
Citizens Committee for Responsible Government:	
Cohen, Leslie H., legal counsel.....	604
Newton, Donald C., insurance actuary.....	608
Robinson, John, chairman.....	601
Sullivan, Dr. Thomas H., member, board of directors.....	615
Clement, Kenneth W., M.D., Cleveland, Ohio.....	1380
Cleveland Welfare Federation of Mary Adelaide Mendelson, associate executive secretary.....	860
Cohen, Joseph, Washington representative, National Association of Retail Druggists.....	1691
Cohen, Leslie H., legal counsel, Citizens Committee for Responsible Government.....	604
College of American Pathologists, Dr. Ernest E. Simard, president.....	1115
Commerce and Industry Association of New York, Mahlon Z. Eubank, director, social insurance department.....	1842
Community Council of Greater New York, James W. Fogarty, executive director.....	2011
Conley, Dr. Veronica, former executive director, National Association for Practical Nurse Education and Service.....	995
Conway, Bernard J., chief legal officer, American Dental Association.....	1062
Corcoran, Msgr. Lawrence J., secretary, National Conference of Catholic Charities.....	1819
Council of State Chambers of Commerce, Paul P. Henkel, chairman, social security committee.....	1306
Council on Social Work Education:	
Stein, Dr. Herman D., president.....	1730
Sister Mary Immaculate, member of the board.....	1730
Council on Social Work Education, advisory committee on undergraduate education, and California Deans of Social Welfare and Social Work, Ernest F. Witte.....	1921
Crosby, Dr. Edwin L., executive vice president, American Hospital Association.....	726
Crothers, Dr. Morris, member, State of Oregon House of Representatives.....	1760
Diamond, Bernard I., chairman, government and professional relations council, American Association of Bioanalysts.....	1050
Dick, Judah, Esq., New York, N. Y.....	1540
Dingell, Hon. John D., a Representative in Congress from the State of Michigan.....	1896
Dow, Hon. John G., a Representative in Congress from the State of New York.....	1893
Edelman, John W., president, National Council of Senior Citizens.....	1356
Egger, Roscoe L., Jr., taxation committee, Chamber of Commerce of the United States.....	1347
Elliott, John Doyle, National Townsend Plan.....	2019
Ellis, William C., counsel Massachusetts Society of Registered Physical Therapists.....	1056
Eppert, Ray R., American Hospital Association.....	693
Erbe, Hon. Norman A., executive director, American Chiropractic Asso- ciation.....	982
Essex County, N.J., Board of Freeholders, Charles A. Matthews, director.....	1256
Eubank, Mahlon Z., director, social insurance department, Commerce and Industry Association of New York.....	1842
Evans, James A., public relations counsel, presenting statement of Myrtle Williams, president, National League of Senior Citizens.....	1624
Farbstein, Hon. Leonard, a Representative in Congress from the State of New York.....	1918
Federation of American Hospitals, Leon Goodman, executive director.....	771
Fischer, Dr. Carl H., graduate school of business administration, Univer- sity of Michigan.....	1402
Fitch, William C., executive director, American Association of Retired Persons, and National Retired Teachers Association.....	1247
Fleming, Scott, vice president and associate manager, Kaiser Foundation Health Plan, Inc.....	780

	Page
Flemming, Arthur S., president, National Council of Churches of Christ in the U.S.A.-----	1268
Flynn, Gerald M., adviser, Senior Citizens Golden Ring Council.-----	1075
Fogarty, James W., executive director, Community Council of Greater New York-----	2011
Ford, Hon. Gerald R., a Representative in Congress from the State of Michigan-----	1267
Fraser, Hon. Donald M., a Representative in Congress from the State of Minnesota-----	1155
Freitag, William, American Hospital Association-----	687
Fry, Dr. Franklin Clark, president, Lutheran Church in America-----	1165
Ganser, Dr. Leonard, vice president, National Association of State Mental Health Program Directors-----	1080
Gardner, Dr. Lytt I., national chairman, Physicians Forum-----	1142
Gibson, Dr. Robert W., American Pshychiatric Association and National Association of Private Psychiatric Hospitals-----	1080
Ginsberg, Mitchell I., commissioner, New York Department of Welfare--	1832
Glasser, Melvin A., chairman, commission on social action, and Dr. Charles I. Schottland, president-elect, National Association of Social Workers-----	1697, 1713
Goddard-Riverside Community Center, Mrs. Sarah Pollock-----	1881
Goodman, Leon, executive director, Federation of American Hospitals---	771
Graham, Dr. George W., American Hospital Association-----	721
Gubser, Hon. Charles S., a Representative in Congress from the State of California-----	1061
Guttmacher, Dr. Alan F., president, Planned Parenthood-World Population-----	1501
Hall, Hon. Durward G., a Representative in Congress from the State of Missouri-----	1197
Harrison, Bernard, legislative department, American Medical Association--	1651
Haskins, Ralph S., national president, American Medical Technologists---	974
Health Insurance Association of America, Charles A. Siegfried, vice president-----	937
Henkel, Paul P., chairman, social security committee, Council of State Chambers of Commerce-----	1306
Henry Street Settlement: Kron, Mrs. Maria-----	1881
Werbell, Mrs. Sarah-----	1881
Hicks, W. B., Jr., executive secretary, Liberty Lobby-----	1626
Hilltop Laboratories, George L. Quisno-----	989
Horton, Hon. Frank J., a Representative in Congress from the State of New York-----	1773
Hudson, Dr. Charles L., president, American Medical Association-----	1651
Hudson Guild: McDonough, Mrs. Ethel-----	1881
Tobin, James F-----	1881
Hutton, William, executive officer, National Council of Senior Citizens---	1363
Illinois Department of Children and Family Services, Dr. Cyril H. Winking, deputy director-----	1529
Illinois State Chamber of Commerce, William H. Lowe, chairman, public assistance and welfare committee-----	1865
International Association of Fire Fighters, Leonard B. Kershner, member, legislative committee-----	1485
International Chiropractors Association, Dr. Grady V. Lake, vice president--	1558
International Society of Clinical Laboratory Technologists, Tom Robinson, president, and Stanley Reitman, member, board of directors-----	991
Insurance, company intermediaries (Aetna Life Insurance Co., etc.), Daniel W. Pettengill, vice president, Aetna Life and Casualty-----	449
Izquierdo-Mora, Dr. Luis A., president, and Dr. J. A. Alvarez-De Choudens, president-elect, Puerto Rico Medical Association-----	1630
Jackson, Frank M., president, National Council on Teacher Retirement of the National Education Association-----	1251
Jaspan, Daniel, legislative representative, National Association of Postal Supervisors-----	1264
Jenkins, Thomas M., president, American Association of Homes for the Aging-----	1003

	Page
Johnson, Hon. Harold T., a Representative in Congress from the State of California.....	1205
Johnson, Lewis J., National Farmers Union.....	1283
Kaiser Foundation Health Plan, Inc., Scott Fleming, vice president and associate manager.....	780
Kalmykow, Andrew, counsel, American Insurance Association.....	1244
Kennedy, Jack, president, National Conference on Public Employee Retirement Systems.....	1253
Kershner, Leonard B., member, legislative committee, International Association of Fire Fighters.....	1485
King, Raymond E., Jr., chairman, committee on social security, National Association of Life Underwriters.....	1229
Kron, Mrs. Maria, Henry Street Settlement.....	1881
Kupferman, Hon. Theodore R., a Representative in Congress from the State of New York.....	1411
Lake, Dr. Grady V., vice president, International Chiropractors Association.....	1558
Lenox Hill Neighborhood Association, Ludwig Adam.....	1881
Lesser, Leonard, general counsel, industrial union department, AFL-CIO.....	1420
Liberty Lobby, W. B. Hicks, Jr., executive secretary.....	1626
Lichtenstein, Zalman J., executive director, Senior Citizens Golden Ring Council.....	1075
Life Insurance Association of America, and American Life Convention, George W. Young, chairman, joint social security committee.....	1210
Lowe, William H., chairman, public assistance and welfare committee, Illinois State Chamber of Commerce.....	1865
Lutheran Church in America, Dr. Franklin Clark Fry, president.....	1165
McCabe, John C., president, Michigan Blue Shield, director, National Association of Blue Shield Plans.....	529, 534
McDaniel, Durward, legislative chairman, American Council of the Blind.....	1999
McDonough, Mrs. Ethel, Hudson Guild.....	1881
McGarry, Mrs. Barbara D., executive director, American Parents Committee.....	2005
McGaughey, John R., director, division of child guardianship, Massachusetts Department of Public Welfare.....	2043
McNerney, Walter J., president, Blue Cross Association.....	477
MacDougall, William R., secretary, committee on welfare, National Association of Counties.....	1779
Machen, Hon. Hervey G., a Representative in Congress from the State of Maryland.....	1555
Mary Immaculate, Sister, member of the board, Council on Social Work Education.....	1730
Massachusetts Federation of Nursing Homes, Arthur Stein, treasurer.....	1059
Massachusetts Department of Public Welfare, John R. McGaughey, director, division of child guardianship.....	2043
Massachusetts Society of Registered Physical Therapists, William C. Ellis, counsel.....	1056
Matsunaga, Hon. Spark M., a Representative in Congress from the State of Hawaii.....	1551
Matthews, Charles A., director, Essex County, N.J., Board of Freeholders.....	1256
Meals, James, director, governmental and legislative affairs, Air Line Pilots Association.....	1491
Meany, George, president, American Federation of Labor and Congress of Industrial Organizations (AFL-CIO).....	571
Megal, Carl J., Washington representative, American Federation of Teachers.....	1483
Melton, Mrs. Marjorie, National Farmers Union.....	1293
Mendelson, Mary Adelaide, associate executive secretary, Welfare Federation of Cleveland.....	860
Morris, Stephen J., American Nursing Home Association.....	808
Moss, A. J., commissioner, Arkansas State Department of Public Welfare.....	1788
Mowbray, Dr. Douglas T., president, American Podiatry Association.....	1137
Mueller, William J., American Hospital Association.....	701

	Page
Murphy, Hon. John M., a Representative in Congress from the State of New York.....	1409
Nagle, John F., chief, Washington office, National Federation of the Blind.....	1811
National Association for Practical Nurse Education & Service: Conley, Veronica, Dr., former executive director.....	995
Pickens, John K., general counsel.....	995
National Association of Blue Shield Plans. (<i>See</i> Blue Shield Plans, National Association of.)	
National Association of Counties, William R. MacDougall, secretary, committee on welfare.....	1779
National Association of Life Underwriters, Raymond E. King, Jr., chairman, committee on social security.....	1229
National Association of Postal Supervisors, Daniel Jaspan, legislative representative.....	1264
National Association of Private Psychiatric Hospitals and American Psychiatric Association, Dr. Robert W. Gibson.....	1080
National Association of Retail Druggists, Joseph Cohen, Washington representative.....	1691
National Association of Social Workers: Glasser, Melvin A., chairman, commission on social action.....	1697, 1713
Schottland, Dr. Charles I., president-elect.....	1697
National Association of State Mental Health Program Directors, Dr. Leonard Ganser, vice president.....	1080
National Committee for the Day Care of Children, Mrs. Carroll Perry, Jr., legislative chairman.....	1622
National Conference of Catholic Charities, Msgr., Lawrence J. Corcoran, secretary.....	1819
National Conference on Public Employee Retirement Systems, Jack Kennedy, president.....	1253
National Conference of State Social Security Administrators: Biegalle, Murray L.....	1482
Blechinger, Carl J.....	1481
Reeves, Miss Edna M., chairman, legislative committee.....	1476
National Council of Churches of Christ in the U.S.A., Arthur S. Flemming, president.....	1268
National Council of Senior Citizens: Edelman, John W., president.....	1356
Hutton, William, executive officer.....	1363
Newburgher, Walter, national vice president.....	1371
O'Brien, James Cuff, assistant to the president.....	1358
National Education Association, National Council on Teacher Retirement: Jackson, Frank M., president.....	1251
Pyle, Hoyte, legislative committee chairman.....	1250
National Farmers Union: Carstenson, Blue A., assistant legislative director.....	1294
Johnson, Lewis J.....	1283
Melton, Mrs. Marjorie.....	1293
National Federation of the Blind, John F. Nagle, chief, Washington office.....	1811
National League of Senior Citizens, Myrtle Williams, president, presented by James A. Evans, public relations counsel.....	1624
National Postal Union, David Silvergleid, secretary-treasurer.....	1613
National Retired Teachers Association and American Association of Retired Persons, William C. Fitch, executive director.....	1247
National Social Welfare Assembly, Miss Elizabeth Wickenden, technical consultant on public social policy.....	1563
National Townsend Plan, John Doyle Elliott.....	2019
National Urban League, Whitney M. Young, executive director.....	1297
New Jersey (Essex County), Board of Freeholders, Charles A. Matthews, director.....	1256
New Jersey Community Action Training Institute, Barry Passett, director.....	1192
New York Board of Trade, Dr. George M. Saypol.....	1755
New York City Central Labor Council AFL-CIO, New York Hotel and Motel Trades Council, and New York Labor-Management Council of Health and Welfare Plans, Inc., Walter J. Sheerin.....	1627

CONTENTS

XIII

	Page
New York Department of Welfare, Mitchell I. Ginsberg, commissioner...	1832
Newburgher, Walter, national vice president, National Council of Senior Citizens.....	1371
Newton, Donald C., insurance actuary, Citizens Committee for Responsible Government.....	608
Nichols, Donald H., regional vice president, Air Line Pilots Association.....	1491
O'Brien, James Cuff, assistant to the president, National Council of Senior Citizens.....	1358
O'Connell, Nicholas J., Jr., president, Allied Pilots Association.....	1499
O'Donnell, Charles C., executive director, Senior Citizens & Associates of America.....	1374
Ostrander, Dr. F. Darl, president-elect, American Dental Association.....	1062
Passett, Barry, director, New Jersey Community Action Training Institute.....	1192
Pepper, Hon. Claude, a Representative in Congress from the State of Florida.....	1965
Perry, Mrs. Carroll, Jr., legislative chairman, National Committee for the Day Care of Children.....	1622
Pettengill, Daniel W., vice president, Aetna Life and Casualty, in behalf of insurance company intermediaries (Aetna Life Insurance Co., etc.)..	449
Physicians Forum, Dr. Lytt I. Gardner, national chairman.....	1142
Pickens, John K., general counsel:	
American Nursing Home Association.....	787
National Association for Practical Nurse Education and Service.....	995
Planned Parenthood-World Population:	
Beasley, Dr. Joseph, member of the board.....	1508
Guttermacher, Dr. Alan F., president.....	1501
Polanco-Abreu, Hon. Santiago, Resident Commissioner of Puerto Rico....	1930
Pollock, Mrs. Sarah, Goddard-Riverside Community Center.....	1881
Puerto Rico Medical Association, Dr. Luis A. Izquierdo-Mora, president, and Dr. J. A. Alvarez-De Choudens, president-elect.....	1630
Pyle, Hoyte, legislative committee chairman, National Council on Teacher Retirement of the National Education Association.....	1250
Quisno, George L., Hilltop Laboratories.....	989
Reeves, Miss Edna M., chairman, legislative committee, National Conference of State Social Security Administrators.....	1476
Reid, Joseph H., executive director, Child Welfare League of America....	1984
Reitman, Stanley, member, board of directors; and Tom Robinson, president, International Society of Clinical Laboratory Technologists.....	991
Reuss, Hon. Henry S., a Representative in Congress from the State of Wisconsin.....	1556
Reuther, Walter P., president, United Auto Workers of America.....	1420
Rhodes, Hon. George M., a Representative in Congress from the State of Pennsylvania.....	1915
Robinson, John, chairman, Citizens Committee for Responsible Government.....	601
Robinson, Tom, president, and Stanley Reitman, member, board of directors, International Society of Clinical Laboratory Technologists.....	991
Rosanetz, Herman, New York, N. Y.....	1640
Rouse, Dr. Milford O., president-elect, American Medical Association....	1651
Ruff, Mrs. Rhoda A., chairman, Affiliated Government Organizations....	1619
Ryan, Hon. William F., a Representative in Congress from the State of New York.....	1202
St Germain, Hon. Fernand J., a Representative in Congress from the State of Rhode Island.....	1207
Saypol, Dr. George M., New York Board of Trade.....	1755
Schafer, Joseph A., C.P.A., Philadelphia, Pa.....	1543
Schmidt, Wilbur J., chairman, national council of state public welfare administrators, American Public Welfare Association.....	831
Schottland, Dr. Charles I., president-elect, and Melvin A. Glasser, chairman, commission on social action, National Association of Social Workers.....	1697
Schweiker, Hon. Richard S., a Representative in Congress from the State of Pennsylvania.....	564
Schwengel, Hon. Fred, a Representative in Congress from the State of Iowa.....	1906

	Page
Seidman, Bert, director, social security department, American Federation of Labor and Congress of Industrial Organizations (AFL-CIO).....	571
Selden, Hon. Armistead I., Jr., a Representative in Congress from the State of Alabama.....	1476
Senior Citizens & Associates of America, Charles C. O'Donnell, executive director.....	1374
Senior Citizens Golden Ring Council:	
Flynn, Gerald M., adviser.....	1075
Lichtenstein, Zalman J., executive director.....	1075
Sheerin, Walter J., New York City Central Labor Council, AFL-CIO, New York Hotel and Motel Trades Council, and New York Labor-Management Council of Health and Welfare Plans, Inc.....	1627
Siegfried, Charles A., vice president, Health Insurance Association of America.....	937
Silvergleid, David, secretary-treasurer, National Postal Union.....	1613
Simard, Dr. Ernest E., president, College of American Pathologists.....	1115
Sisk, Hon. B. F., a Representative in Congress from the State of California.....	1090
Slade, Mrs. Pauline, cochairman, policy committee, Welfare Alliance of Washington, D.C.....	2055
Smith, Marvin, American Nursing Home Association.....	822
Smith, Wallace M., manager, mid-Atlantic office, American Mutual Insurance Alliance.....	1645
Society for Pediatric Research, Association of Medical School Pediatric Department Chairmen, American Academy of Pediatrics, and American Pediatric Society, Dr. Ralph Wedgwood.....	1171
Stein, Arthur, treasurer, Massachusetts Federation of Nursing Homes.....	1059
Stein, Dr. Herman D., president, Council on Social Work Education.....	1730
Stratton, Hon. Samuel S., a Representative in Congress from the State of New York.....	1951
Sullivan, Cliff, Indianapolis, Ind.....	1891
Sullivan, Dr. Thomas H., member, board of directors, Citizens Committee for Responsible Government.....	615
Teague, Hon. Olin E., a Representative in Congress from the State of Texas.....	1207
Tenzer, Hon. Herbert, a Representative in Congress from the State of New York.....	1908
Terris, Dr. Milton, president, American Public Health Association.....	1129
Tobin, James F., Hudson Guild.....	1881
United Auto Workers of America, Walter P. Reuther, president.....	1420
United Steelworkers of America District 20, Pennsylvania, Michael J. Zahorsky.....	641
Volpitto, Dr. Perry P., past president, American Society of Anesthesiologists.....	1809
Waldie, Hon. Jerome R., a Representative in Congress from the State of California.....	1164
Walker, Edward, president, American Nursing Home Association.....	787
Walters, Thomas G., legislative representative, American Federation of Government Employees.....	1607
Wedgwood, Dr. Ralph, Association of Medical School Pediatric Department Chairmen, American Academy of Pediatrics, American Pediatric Society, and Society for Pediatric Research.....	1171
Welfare Alliance of Washington, D.C., Mrs. Pauline Slade, cochairman, policy committee.....	2055
Welfare Federation of Cleveland, Mary Adelaide Mendelson, associate executive secretary.....	860
Werbell, Mrs. Sarah, Henry Street Settlement.....	1881
Wick, Charles Z., American Nursing Home Association.....	825
Wickenden, Miss Elizabeth, technical consultant on public social policy, National Social Welfare Assembly.....	1563
Williams, Myrtle, president, National League of Senior Citizens, presented by James A. Evans, public relations counsel.....	1624
Williamson, Kenneth, associate director, American Hospital Association.....	735
Winking, Dr. Cyril H., deputy director, Illinois Department of Children and Family Services.....	1529

	Page
Witte, Ernest F., California Deans of Social Welfare and Social Work and the Advisory Committee on Undergraduate Education of the Council on Social Work Education.....	1921
Wogan, Everett A., Wogan Laboratories.....	989
Young, George W., chairman, joint social security committee, American Life Convention, and Life Insurance Association of America.....	1210
Young, Whitney M., executive director, National Urban League.....	1297
Zablocki, Hon. Clement J., a Representative in Congress from the State of Wisconsin.....	559
Zahorsky, Michael J., United Steelworkers of America District 20 (Pennsylvania).....	641

MATERIAL SUPPLIED FOR THE RECORD

Adams, James P., M.D., American Academy of Orthopaedic Surgeons, letter dated March 30, 1967, to Chairman Mills.....	2350
Adams, Ruth R., professor of social work, Howard University, letter dated March 28, 1967, to Chairman Mills.....	2411
Alabama Department of Pensions and Security, Ruben H. King, commissioner, letter dated April 11, 1967, to Chairman Mills.....	2369
Alabama Hospital Association, G. C. Long, Jr., executive director, letter dated March 16, 1967, to Chairman Mills.....	2281
Alabama League of Aging Citizens, Inc., Rubin M. Hanan, president, letters dated March 13, 1967, and March 5, 1967, to Chairman Mills.....	2378
Alexandria (Va.) Clinical Laboratory, Guide F. Cammisia, letter dated March 7, 1967, to Chairman Mills forwarding letter addressed to Hon. John W. Gardner, Secretary of HEW, dated March 6, 1967.....	2294
Allison, Edward L., Allison & Clark, letter dated March 13, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee.....	2441
Alvarez-De Choudens, Dr. J. A. (See Puerto Rico Medical Association.)	
Amalgamated Meat Cutters and Butcher Workmen of North America, Thomas J. Lloyd, international president, and Patrick E. Gorman, secretary-treasurer, letter dated April 5, 1967, to Chairman Mills.....	600
American Academy of Orthopaedic Surgeons, James P. Adams, M.D., letter dated March 30, 1967, to Chairman Mills.....	2350
American Academy of Pediatrics. (See Dr. Ralph Wedgwood.)	
American Association of Bioanalysts, George M. Maruyama, M.S., president, letter dated March 6, 1967, to Chairman Mills.....	1055
American Association of Homes for the Aging, Thomas M. Jenkins, president, telegram dated April 17, 1967, to Chairman Mills.....	1009
American Association of Hospital Accountants, South Western Pennsylvania Chapter, Harold W. Luebs, chairman, accounting and statistical committee, letter dated March 17, 1967, to Leo Irwin, chief counsel, Ways and Means Committee.....	2251
American Association of Ophthalmology, Arthur D. Collins, M.D., chairman, committee on public affairs, letter dated April 5, 1967, to Chairman Mills, with enclosure entitled "Public Confusion Regarding Eye Care".....	2343
American Association of Workers for the Blind, Sidney B. Cohen, executive secretary, statement.....	2243
American Chiropractic Association, Norman A. Erbe, executive director:	
Appendix I—Education requirements for licensure as doctor of chiropractic.....	987
Appendix II—Proposed amendment to H.R. 5710 to include chiropractic services in medicare.....	987
Supplements A and B.....	987
American College of Foot Orthopedists, Richard H. Lanham, Jr., D.S.C., letter dated March 7, 1967, to Chairman Mills.....	2351
American College of Radiology:	
Calhoun, Dr. Joseph D., chairman, board of chancellors, letter from Arkansas Blue Cross and Blue Shield, Inc., Sam M. Butler, president, dated April 3, 1967.....	1808
Kansas Chapter, Kansas Radiological Society, John W. Travis, M.D., chairman, committee on legislation and public relations, letter dated March 4, 1967, to Congressman Chester L. Mize, with forwarding letter, and letter dated March 15, 1967, to Chairman Mills.....	2341

	Page
American Dental Association, Dr. F. Darl Ostrander, president-elect, report on dental prepayment plans in the United States.....	1068
American Farm Bureau Federation, statement.....	2114
American Federation of Government Employees, Social Security Lodge No. 1760, Jack P. Daniels, counsel, letter dated March 21, 1967, to Ways and Means Committee.....	2258
American Federation of Labor and Congress of Industrial Organizations (AFL-CIO). (See Meany, George, president.)	
American Foundation for the Blind, Inc., Irvin P. Schloss, legislative analyst, statement.....	2241
American Home Economics Association, Helen J. Mandigo, president, telegram dated March 21, 1967, to Chairman Mills.....	2399
American Hospital Association:	
Crosby, Dr. Edwin L., executive vice president, Amendment to H.R. 5710, to add a new paragraph (18) to section 501(c) of the Internal Revenue Code.....	731
Mueller, William J., table entitled "Pertinent statistics with respect to recent mortgage loans made to hospitals during 1965-66".....	710
Williamson, Kenneth, director, letter dated April 13, 1967, to Chairman Mills, with attachments—Summary of data on recognition of hospital financial needs in Blue Cross payment formulas; statement on reimbursement; and Factors to evaluate in the establishment of hospital charges.....	751
American Hotel & Motel Association, Arthur J. Packard, Sr., chairman, governmental affairs committee, statement.....	2135
American Legion:	
Corcoran, John J., director, national rehabilitation commission, statement.....	2222
Shake, Randel, director, national child welfare division, statement.....	2214
Stringer, Herald E., director, legislative commission, letter dated April 24, 1967, to Chairman Mills, with statement of John J. Corcoran, director, national rehabilitation commission, attached....	2222
American Life Convention. (See Young, George W.)	
American Lutheran Church, division of pensions, George H. Berkheimer, executive director, letter dated March 15, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee.....	2356
American Medical Technologists, Ralph S. Haskins, national president:	
Appendix 1—Medical technology program.....	979
Appendix 2—Minimum course requirements of American medical technologist accredited schools.....	980
Appendix 3—Program of instruction for medical laboratory procedures (advanced) course, Letterman General Hospital, San Francisco, Calif.....	981
American Nurses' Association, statement.....	2227
American Nursing Home Association:	
Morris, Stephen J., Profile of Nursing Homes, 1967.....	817
Pickens, John K., general counsel:	
Letter dated August 6, 1965, to Hon. John W. Gardner, Secretary, HEW, from Roy J. McDonald, president, American Nursing Home Association.....	796
Letter dated January 16, 1967, to Hon. John Gardner, Secretary of HEW.....	797
Letter dated February 25, 1967, from Wilbur J. Cohen, Under Secretary, HEW.....	801
Letter dated March 1, 1967, to Ed Walker, president, American Nursing Home Association, from Wilbur J. Cohen, Under Secretary, HEW, with attachment.....	803
Letter dated March 8, 1967, to Hon. Wilbur Cohen, Under Secretary, HEW.....	805
Smith, Marvin, Comparison of: I. Original HEW formula; with II. Substitute formula; with III. Original Miller bill.....	824
Zelenka, Frank G., assistant executive director, letter dated May 8, 1967, to Congressman Al Ullman, Ways and Means Committee, with attachments re total number of extended care facilities certified for medicare, some figures relating to nursing home construction, and an index of the difference between the ordinary charges and the approved reimbursement.....	830

	Page
American Optometric Association, W. Judd Chapman, O.D., chairman, legislative committee:	
Amendment to H. R. 5710.....	1100
Attachment A—Services.....	1100
Attachment B—Glossary.....	1101
Attachment C—Definition of physicians.....	1102
Attachment D—Ohio State University, School of Optometry curriculum, 1966-67.....	1103
Attachment E—State board examinations.....	1107
Attachment F—Bills to amend title XVIII of the Social Security Act to provide payment for optometrists' serviced under the program of supplementary medical insurance benefits for the aged as of March 8, 1967.....	1107
Attachment G—Points considered by optometrists to be essential in any arrangements for provisions of vision services.....	1107
American Parents Committee, Mrs. Barbara D. McGarry, executive director:	
Attachment 1—Table 1.n.2.—M. & I. projects: Preliminary statistical report, 1st half of fiscal year 1967.....	2009
Attachment 2—Resolution of the American Parents Committee in support of the U.S. Children's Bureau activities.....	2010
American Pediatric Society (<i>see also</i> Dr. Ralph Wedgwood):	
Gordon, Harry H., M.D., president, telegram dated March 13, 1967, to Chairman Mills.....	1192
American Physical Therapy Association, Lucy Blair, executive director, letters dated March 16, 1967, with attachments, and April 11, 1967, to Chairman Mills.....	2351
American Podiatry Association, Dr. Douglas T. Mowbray, president, payment for podiatrists' services under supplementary medical insurance program (H. Rept. 2300, 89th Cong., second sess.).....	1139
American Psychiatric Association, Harvey J. Tompkins, M.D., president, letter dated April 12, 1967, to Chairman Mills.....	1089
American Psychological Association:	
Brayfield, Dr. Arthur H., executive officer:	
A critical look at professional education in the mental health field.....	1018
Appendix A—APA approved doctoral programs in clinical and in counseling psychology: 1965.....	1038
Appendix B—Standard for APA directory listings of private practice.....	1039
Appendix C—Ethical standards of psychologists.....	1040
Appendix D—State regulation of the practice of psychology.....	1045
The physician and the clinical psychologist—A comparison of their education and their interrelationship.....	1011
The psychologist and voluntary health insurance.....	1030
McMillan, John J., administrative officer, State and professional affairs, letter dated April 12, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee.....	1048
American Public Health Association, Dr. Milton Terris, president, letter dated April 5, 1967, to Chairman Mills.....	1137
American Public Welfare Association, Wilbur J. Schmidt, chairman, national council of State welfare administrators:	
Federal legislative objectives, 1967 (prepared by a special ad hoc committee, approved by the board of directors, December 8, 1966).....	845
Financing Public Child Welfare Services (policy statement developed and approved by the committee on services for children and youth, December 1965, and adopted by the board of directors, June 13, 1966).....	850
Social work manpower (excerpts from letters written by administrators of State departments of public welfare, with reference to proposed legislation to authorize a program of grants to schools of social work.....	854
American Retail Federation, statement.....	2117
Annuity Fund for Congregational Ministers, Wm. Kincaid Newman, executive vice president, letter dated March 29, 1967, to Chairman Mills.....	2357

	Page
Arkawy, Norman M., Esq., Rye, N.Y., statement.....	2437
Arnold, Arthur M. (<i>See</i> Commerce and Industry Association of New York Association of New York State Physicians and Dentists, E. J. Felderman, M.D., president, statement.....)	1727
Association of Professors of Gynecology and Obstetrics, Harry Prystowsky, M.D., president, statement.....	2430
Association of State and Territorial Health Officers, John H. Venable, M.D., president, letter dated April 5, 1967, to Chairman Mills.....	2263
Augustana College, Department of Sociology and Social Work, Frithjof O. M. Westby, chairman, letter dated March 28, 1967, to Chairman Mills.....	2407
Babbidge, Homer D., Jr., president, University of Connecticut, letter dated March 7, 1967, to Chairman Mills.....	2409
Babson, William W., M.D., president, Massachusetts Medical Society, letter dated March 8, 1967, to Chairman Mills.....	2301
Baltimore, city of:	
Hochreiter, Franklyn C., executive secretary, Commission of Problems of the Aging, statement.....	2359
McKeldin, Theodore R., mayor, statement.....	2358
Beasley, Dr. Joseph. (<i>See</i> Planned Parenthood-World Population.)	
Beattie, Donald S., executive secretary, Railway Labor Executives' Association, letter dated April 7, 1967, to Chairman Mills.....	601
Beck, Carl A., president, National Small Business Association, letter dated April 10, 1967, to Ways and Means Committee.....	2090
Behlen, Frieda J., O.T.R., associate professor of education, director, occupational therapy program, School of Education, New York University, letter dated March 23, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee.....	2403
Bellevue Maternity Hospital, Schenectady, N.Y., G. Jorgensen, M.D., director, letter dated March 7, 1967, to Chairman Mills.....	2282
Bennett, Howard L., executive secretary, Paralyzed Veterans of America, statement.....	2224
Bergen, Thomas J., executive secretary and legal counsel, Wisconsin Association of Nursing Homes, Inc., statement.....	2286
Berkheimer, George H., executive director, American Lutheran Church, division of pensions, letter dated March 15, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee.....	2356
Besse, Ralph M., chairman, Cleveland Inner City Action Committee, letter dated April 5, 1967, to Chairman Mills.....	2066
Bethesda United Presbyterian Church Community Center, Rev. David R. Preininger, program director, letter dated March 15, 1967, to Congressman Elmer J. Holland, with forwarding letter.....	2414
Bevill, Tom., a Representative in Congress from the State of Alabama, statement.....	2075
Blackey, Eileen, dean, School of Social Welfare, University of California, Los Angeles, letter dated March 17, 1967, to Chairman Mills.....	2408
Blair, Lucy, executive director, American Physical Therapy Association, letters dated March 16, 1967, and April 11, 1967, with attachments, to Chairman Mills.....	2351
Blinded Veterans Association, James F. C. Hyde, Jr., national president, statement.....	2225
Bliss, James J., executive vice president, National Retail Merchants Association, statement.....	2116
Blue Cross Association, Walter J. McNerney, president:	
Benefits under medicare, utilization of.....	494
Claims process.....	491
Elapsed time study, medicare.....	503
Letter to Commissioner Robert M. Ball, Social Security Administration, dated February 9, 1966, with attachments.....	506
Blue Shield Plans, National Association of, a review of Social Security Administration's comments on the testimony of medicare part B carriers.....	554
Boehm, Werner W., dean, Graduate School of Social Work, Rutgers University, letter dated March 15, 1967, to Chairman Mills.....	2410
Boone, Richard W., executive director, Citizens' Crusade Against Poverty, letter dated April 17, 1967, to Chairman Mills.....	2235

CONTENTS

XIX

	Page
Boston Hospital for Women, John G. Freymann, M.D., general director, letter dated April 3, 1967, to Chairman Mills-----	2279
Brayfield, Dr. Arthur H. (<i>See</i> American Psychological Association.)	
Bridwell, Joseph L., grand master of Masons in the State of Indiana, Conference of Grand Masters of Masons, in North America, letter dated March 20, 1967, with 17 exhibits, to Chairman Mills-----	2145
Brotherhood of Locomotive Engineers, P. S. Heath, grand chief engineer, letter dated April 24, 1967, to Chairman Mills-----	2127
Brubaker, Maurice S., president, Maryland Occupational Therapy Association, letter dated April 18, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee-----	2355
Buchanan, Hon. John J., Jr., a Representative in Congress from the State of Alabama, letter dated March 7, 1967, to Chairman Mills-----	2080
Bullen George S., legislative director National Federation of Independent Business, statement-----	2140
Buonomo, Rizalia president, Health Educators Association of Puerto Rico, telegram dated April 5 1967, to Ways and Means Committee----	1951
Bureau of Salesmen's National Associations Marshall J. Mantler, executive director, statement-----	2111
Burke, Hon. James A., a Representative in Congress from the State of Massachusetts, list of persons throughout the United States who have expressed support of H.R. 1977-----	2048
Burns, Eugene F., director, Cuyahoga County (Ohio) Welfare Department, statement-----	2059
Byers, Lyle W., executive director, Eye and Ear Hospital of Pittsburgh, Pa., letter dated February 24, 1967, to Leo Irwin, Ways and Means Committee-----	2284
Calhoun, Dr. Joseph D., chairman, board of chancellors, American College of Radiology, letter from Arkansas Blue Cross and Blue Shield Inc., Sam M. Butler, president, dated April 3, 1967-----	1808
California, University of, Los Angeles, School of Social Welfare, Eileen Blackey dean, letter dated March 17, 1967, to Chairman Mills-----	2408
Cammisa, Guide F., Alexandria (Va.) Clinical Laboratory, letter dated March 7, 1967, to Chairman Mills forwarding letter addressed to Hon. John W. Gardner Secretary of HEW, dated March 6, 1967-----	2294
Casanova, C. David, Columbus Ohio, letter dated February 28, 1967, to Chairman Mills-----	2442
Catholic Hospital Association, Reverend John J. Flanagan, S.J., executive director, statement-----	2271
Chamber of Commerce of the United States, Don A. Goodall, legislative action general manager, letter dated April 19, 1967, to Chairman Mills--	1355
Chapman, James W., Colonel, USAF, Retired, legislative counsel, Retired Officers Association, letter dated April 18, 1967, to Chairman Mills----	2214
Chapman, Norris E., Denver, Colo., letter dated March 16, 1967, to Chairman Mills-----	2450
Chapman, W. Judd, O.D. (<i>See</i> American Optometric Association.)	
Charlotte County (Fla.) Medical Society, Carl N. Reilly, M.D., secretary, letter dated March 20, 1967, to Chairman Mills, with statement attached-----	2302
Chicago, University of, School of Social Service Administration, Alton A. Linford, dean, letter dated March 7, 1967, to Chairman Mills-----	2408
Christian Science Committee on Publication, First Church of Christ, Scientist, J. Burroughs Stokes, manager, Washington, D.C., office, letter dated March 21, 1967, to Chairman Mills-----	2371
Citizens Committee for Responsible Government, John Robinson, chairman: Exhibit I—Supplementary statement-----	616
Exhibit II—Remarks at hearing on compulsory health insurance, Albany, N. Y.-----	621
Exhibit III—Proposed amendments to New York medicaid-----	624
Exhibit IV—Charts and tables-----	630
Exhibit V—Medicaid amendments, background-----	632
Exhibit VI—The Coming Din of Inequity, from the Journal of the American Medical Association, April 8, 1961-----	632

	Page
Citizens' Crusade Against Poverty, Richard W. Boone, executive director, letter dated April 17, 1967, to Chairman Mills-----	2235
Clement, Kenneth W., M.D., Cleveland, Ohio, appendix A—A participant's view of the role of HIBAC-----	1386
Cleveland, City of, Ralph S. Locher, mayor, letter dated April 6, 1967, to Chairman Mills-----	2066
Cleveland, Hattye M., chairman, legislation committee, New York State Occupational Therapy Association, letter dated April 4, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee-----	2356
Cleveland City Council, James V. Stanton, president, letter to Chairman Mills-----	2066
Cleveland Inner City Action Committee, Ralph M. Besse, chairman, letter dated April 5, 1967, to Chairman Mills-----	2066
Cohen, Sidney B., executive secretary, American Association of Workers for the Blind, statement-----	2243
Colegio de Cirujanos Dentistas de P. R., Dr. Cesar A. Medina, president, and Puerto Rico Dental Association, letter to Chairman Mills, with statement-----	1639-j
College of American Pathologists, E. Barrett Prettyman, Jr., statement to the Social Security Administration, Department of Health, Education, and Welfare on regulations governing hospital-based physicians, July 25, 1966 (placed in record by Congressman Byrnes)-----	1119
College of Social Workers of Puerto Rico, Antonio S. Rodriguez, president, and Elisa Diaz Gonzalez, acting president, Puerto Rico chapter, National Association of Social Workers, letter dated April 3, 1967, to Chairman Mills-----	2360
Collins, Arthur D., M.D., chairman, committee on public affairs, American Association of Ophthalmology, letter dated April 5, 1967, to Chairman Mills, with enclosure entitled "Public Confusion Regarding Eye Care"-----	2343
Collins, John A., Cambridge, Mass., letter dated March 17, 1967, to Congressman Thomas P. O'Neill, Jr., with forwarding letter-----	2436
Colorado Parent Teachers Association, Mrs. W. R. Sanford, chairman, legislation, statement-----	2397
Commerce and Industry Association of New York:	
Arnold, Arthur M., tax counsel, letter dated April 11, 1967, to Chairman Mills-----	1864
Eubank, Mahlon Z., director, social insurance department, Experiodica From North American Reinsurance Corp-----	1842
Community Council of Social Services, Dean A. Gardner, president, letters dated March 16, 1967, and March 22, 1967, with attachment, to Chairman Mills-----	2400
Community Service Society, Charlotte R. Pratt, chairman, committee on family and child welfare, department of public affairs, letter dated April 5, 1967, to Chairman Mills, with enclosed letters dated April 4 and March 30, 1967-----	2364
Connecticut, University of, Homer D. Babbidge, Jr., president, letter dated March 7, 1967, to Chairman Mills-----	2409
Cook, Charles D., M.D., professor of pediatrics and chairman, Department of Pediatrics, School of Medicine, Yale University, letter dated March 13, 1967, to Chairman Mills-----	2398
Cooper Hospital, Camden, N.J., James F. Hannah, assistant administrator-comptroller, letter dated March 28, 1967, to Congressman Richard S. Schweiker, with forwarding letter-----	2079
Corcoran, John J., director, national rehabilitation commission, the American Legion, statement-----	2222
Council of Jewish Federations and Welfare Funds, Inc., Louis J. Fox, president, letter dated March 21, 1967, to Chairman Mills-----	2239
Council of State Chambers of Commerce, Paul P. Henkel, chairman, social security committee:	
Exhibit I—Policy recommendations of the Social Security Committee of the Council of State Chambers of Commerce-----	1313
Exhibit II—Trend in the maximum yearly employee social security tax as amended by Congress-----	1318
Exhibit III—The trend in yearly maximum social security employee tax-----	1319

	Page
Council of State Chambers of Commerce—Continued	
Exhibit IV (p. 1)—Comparison of combined Federal income and social security tax effects on varying levels of taxable income.....	1320
Exhibit IV (p. 2)—Comparison of differences in combined Federal income and social security tax effect on varying levels of taxable income.....	1321
Letter dated March 31, 1967, to Chairman Mills.....	1327
Council on Social Work Education, Dr. Herman D. Stein, president:	
Graduate professional schools of social work in Canada and the United States.....	1735
Non-Government national agency members.....	1748
Undergraduate departments of colleges and universities offering courses with social welfare content.....	1740
Joint supplementary statement with Charles I. Schottland, president, National Association of Social Workers.....	1725
Cowles, Robert, president, Southern Arizona Chapter, National Association of Social Workers, letter dated March 27, 1967, to Chairman Mills....	2399
Creighton University, School of Medicine, Department of Obstetrics and Gynecology, Eugene J. Slowinski, M.D., professor and chairman, letter dated March 17, 1967, to Leo Irwin, chief counsel, Ways and Means Committee.....	2418
Crosby, Dr. Edwin L. (See American Hospital Association.)	
Cuyahoga County (Ohio) Welfare Department, Eugene F. Burns, director, statement.....	2059
Daniels, Jack P., counsel, Social Security Lodge No. 1760, American Federation of Government Employees, letter dated March 21, 1967, to Ways and Means Committee.....	2258
Daughters of Charity of St. Vincent de Paul, St. Louis Province, Harold Hinderer, controller, statement.....	2248
District of Columbia Occupational Therapy Association, Sara Noe Harris, president, letter dated April 2, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee.....	2354
Donnelly, James F., president, Patients' Aid Society, Inc., statement.....	2338
Douds, H. James, general counsel, and David J. Pattison, assistant general counsel, National Association of Life Underwriters, letter dated April 7, 1967, to Chairman Mills, with attachment.....	1237
Dumpson, James R., dean, School of Social Service, Fordham University, letter dated March 20, 1967, to Chairman Mills.....	2409
Duppstadt, Gladys, staff member, National Federation of Settlements and Neighborhood Centers, statement.....	2399
Dyer, John K., Jr., Devon, Pa., letter dated March 23, 1967, to Chairman Mills.....	2438
Eastern Pennsylvania Occupational Therapy Association, George Kovac, president, letter dated March 27, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee.....	2356
Edgar, Richard P., director, department of social welfare, general board of Christian social concerns, Methodist Church, statement.....	1272
Eliot, Martha M., M.D., professor of maternal and child health, emerita, School of Public Health, Harvard University, letter dated March 24, 1967, to Chairman Mills.....	2265
Elliott, John Doyle. (See National Townsend Plan.)	
Elmore, William E., administrator, Paulding Memorial Hospital, Dallas, Ga., letter dated February 20, 1967, to Leo Irwin, chief counsel, Ways and Means Committee.....	2284
Erbe, Norman A. (See American Chiropractic Association.)	
Essex County (N.J.) Welfare Board, Philip K. Lazaro, director, letter dated April 11, 1967, to Chairman Mills.....	1263
Eubank, Mahlon Z. (See Commerce and Industry Association of New York.)	
Eye and Ear Hospital of Pittsburgh, Pa., Lyle W. Byers, executive director, letter dated February 24, 1967, to Leo Irwin, Ways and Means Committee.....	2284
Family Counseling and Children's Services, Bob Weissinger, president, board of directors, letter dated March 29, 1967, to Chairman Mills....	2384

	Page
Family Service of Delaware County (Pa.), Maria E. Shelmire, executive director, letter dated March 30, 1967, to Chairman Mills-----	2411
Federation of American Hospitals, Leon Goodman, executive director, organizations engaged in areawide planning for hospitals and related health facilities-----	776
Felderman, E. J., M.D., president, Association of New York State Physicians and Dentists, statement-----	1727
Feldman, Mrs. John, Silver Spring, Md., letter dated March 27, 1967, to Ways and Means Committee-----	2435
Feldman, Raymond, M.D., associate director, regional programs (mental health), Western Interstate Commission for Higher Education, statement-----	2406
Fiealt, Mrs. Otilie, New York League of Business and Professional Women, Inc., statement-----	2381
Finck, George H., director, Juvenile Welfare Board of Pinellas County, Fla., statement-----	2386
First Church of Christ, Scientist, Christian Science Committee on Publication, J. Burroughs Stokes, manager, Washington, D.C., office, letter dated March 21, 1967, to Chairman Mills-----	2271
Flanagan, Rev. John J., S.J., executive director, Catholic Hospital Association, statement-----	2271
Flemming, Arthur S. (See National Council of Churches of Christ in the U.S.A.)-----	
Flemming, David W., legal counsel, Southern California Pharmaceutical Association, Ltd., statement-----	1696
Florida Occupational Therapy Association, Miss Mary-Alice Murphy, president, letter dated April 3, 1967, to Leo H. Irwin, chief council, Ways and Means Committee-----	2354
Ford, Donald H., dean, College of Human Development, Pennsylvania State University, letter dated April 11, 1967, to Chairman Mills, with attached press release-----	2412
Fordham University, School of Social Service, James R. Dumpson, dean, letter dated March 20, 1967, to Chairman Mills-----	2409
Foster, Charles L., Jr., administrator, Knapp Memorial Methodist Hospital, Weslaco, Tex., letter dated March 22, 1967, to Senator Ralph Yarborough, with forwarding letter from E. (Kika) de la Garza, a Representative in Congress from the State of Texas-----	2284
Fox, Louis J., president, Council of Jewish Federations and Welfare Funds, Inc., letter dated March 21, 1967, to Chairman Mills-----	2239
Freedom, Inc., E. S. Hall, chief engineer, statement-----	2449
Freymann, John G., M.D., general director, Boston Hospital for Women, letter dated April 3, 1967, to Chairman Mills-----	2279
Friedel, Hon. Samuel N., a Representative in Congress from the State of Maryland, letter dated March 7, 1967, to Chairman Mills, with attachment-----	2076
Fuqua, Karey, administrator, Southwestern Clinic Hospital, Inc., Lawton, Okla., letter dated March 14, 1967, to Chairman Mills-----	2283
Gallardo, Efrain Flores, president, Puerto Rico Hospital Association, letter dated April 6, 1967, to Chairman Mills-----	2273
Ganser, Dr. Leonard. (See National Association of State Mental Health Program Directors.)-----	
Gardner, Dean A., president, Community Council of Social Services, letters dated March 16, 1967, and March 22, 1967, with attachments, to Chairman Mills-----	2400
Goldblatt, Louis, secretary-treasurer, International Longshoremen's and Warehousemen's Union, statement-----	2131
Gonzalez, Elsa Diaz, acting president, Puerto Rico chapter, National Association of Social Workers, and Antonio S. Rodriguez, president, College of Social Workers of Puerto Rico, letter dated April 3, 1967, to Chairman Mills-----	2360
Goodall, Don A., legislative action general manager, Chamber of Commerce of the United States, letter dated April 19, 1967, to Chairman Mills-----	1355
Goodman, Leon, executive director, Federation of American Hospitals, organizations engaged in areawide planning for hospitals and related health facilities-----	776

	Page
Goodman, Sidney A., president, National Postal Union, statement-----	1615
Gordon, Harry H., M.D., president, American Pediatric Society, telegram dated March 13, 1967, to Chairman Mills-----	1192
Gorman, Patrick E., secretary-treasurer, and Thomas J. Lloyd, international president, Amalgamated Meat Cutters and Butcher Workmen of North America, letter dated April 5, 1967, to Chairman Mills-----	600
Gouley, Mrs. Benjamin A., president, Jewish Family Service of Philadelphia, letter dated March 29, 1967, to Chairman Mills-----	2414
Government Employees' Council, AFL-CIO, statement-----	2261
Graham, Harry L., legislative representative, National Grange, letter dated April 11, 1967, to Chairman Mills-----	2115
Grais, S. S., chairman, county welfare board, Ramsey County (Minn.) Welfare Department, letter dated March 15, 1967, to Chairman Mills, with attachment-----	2426
Green, McReynolds & Sherrell, certified public accountants, Louie B. Green, C.P.A., letter dated March 8, 1967, to Chairman Mills-----	2254
Greenberg, Irving, executive director, Jewish Counseling and Service Agency, letter dated March 21, 1967, to Chairman Mills-----	2397
Gross, Dr. T. A., president, Terrebonne Parish (La.) Medical Society, letter dated March 30, 1967, to Chairman Mills-----	2300
Gross, Harry L., chairman of the board, Iowa Mutual Tornado Insurance Association, letter dated April 18, 1967, to Chairman Mills-----	2251
Guild, Carl H., M.D., Bartlesville, Okla., letter dated March 22, 1967, to Chairman Mills, with attachments-----	2305
Hackett, Charles J., administrator, Hempstead (N.Y.) General Hospital, letter dated March 2, 1967, to Chairman Mills-----	2282
Haggerty, Robert J., M.D., professor and chairman, Department of Pediatrics, University of Rochester School of Medicine, telegram dated March 14, 1967, to Hon. Barber B. Conable-----	1192
Haines, Avise M., chairman, legislative committee, Missouri Occupational Therapy Association, letter dated March 30, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee-----	2355
Hall, E. S., chief engineer, Freedom, Inc., statement-----	2449
Hanan, Rubin M., president, Alabama League of Aging Citizens, Inc., letters dated March 5, 1967, and March 13, 1967, to Chairman Mills-----	2378
Hannah, James F., assistant administrator-comptroller, Cooper Hospital, Camden, N.J., letter dated March 28, 1967, to Congressman Richard S. Schweiker, with forwarding letter-----	2079
Harmon, Maurice A., commissioner, Kentucky Department of Child Welfare, letter dated March 20, 1967, to Chairman Mills-----	2392
Harris, Sara Noc, president, District of Columbia Occupational Therapy Association, letter dated April 2, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee-----	2354
Harvard University, School of Public Health, department of maternal and child health:	
Eliot, Martha M., M.D., professor of maternal and child health, emerita, letter dated March 24, 1967, to Chairman Mills-----	2265
Schmidt, William M., M.D., professor of maternal and child health and head of department, letter dated March 28, 1967, to Chairman Mills-----	2269
Haskins, Ralph S. (See American Medical Technologists.)	
Haskins & Sells, certified public accountants, John W. Queenan, managing partner, letter dated March 17, 1967, to Chairman Mills-----	2253
Health and Welfare Association of Allegheny County, Pa., Saul F. Shapira, president, letter dated March 31, 1967, to Chairman Mills-----	2417
Health and Welfare Council of the Baltimore Area, Inc., Joseph H. Purdy, president, letter dated April 21, 1967, to Chairman Mills-----	2417
Health Educators Association of Puerto Rico, Rizalia Buonomo, president, telegram dated April 5, 1967, to Ways and Means Committee-----	1951
Health Insurance Association of America, Charles A. Siegfried, vice president:	
Letter dated March 23, 1967, to Chairman Mills; 11 questions and answers with attachment-----	945
Policy with respect to medical expense insurance, statement of-----	941

	Page
Heath, P. S., grand chief engineer, Brotherhood of Locomotive Engineers, letter dated April 24, 1967, to Chairman Mills.....	2127
Hempstead, N. Y., General Hospital, Charles J. Hackett, administrator, letter dated March 2, 1967, to Chairman Mills.....	2282
Hendrickson, Glenn A., Mrs. G. A., Dearborn, Mich., letter dated April 14, 1967, to Congressman John Dingell, with forwarding letter.....	2077
Henkel, Paul P. (See Council of State Chambers of Commerce.)	
Hiett, Miss Naomi, executive director, Illinois Commission on Children, letter dated March 9, 1967, to Chairman Mills.....	2416
Hill, Paul D., CLU, chairman, legislative committee, International Association of Health Underwriters, statement.....	2453
Hilliard, Carey W., president, National Rural Letter Carriers' Association, letter dated March 8, 1967, to Chairman Mills.....	2257
Hinderer, Harold, controller, Daughters of Charity of St. Vincent de Paul, St. Louis Province, statement.....	2248
Hobson, Raleigh C., director, Maryland Department of Public Welfare, letter dated March 13, 1967, to Congressman George H. Fallon, with forwarding letter.....	2393
Hochreiter, Franklyn C., executive secretary, Baltimore City Commission of Problems of the Aging, statement.....	2359
Hockstad, Robert A., grand master of Masons in the State of Michigan and chairman, Conference of Grand Masters of Masons in North America, letter dated March 15, 1967, to Chairman Mills.....	2142
Hood, Mrs. Margaret, director, Tooele County, Utah Department of Public Welfare, letter dated March 17, 1967, to Chairman Mills.....	2412
Horn, H. G. "Bud", president, United Good Neighbors, letter dated March 24, 1967, to Chairman Mills.....	2386
Hospital Planning Council for Metropolitan Chicago, Hiram Sibley, executive director, letter dated April 4, 1967, to Congressman Frank Annunzio, with attachment, with forwarding letter.....	2275
Houston, Community Welfare Planning Association of Greater, Robert M. Ives, president, letter dated March 28, 1967, to Chairman Mills.....	2396
Howard University, Ruth R. Adams, professor of social work, letter dated March 28, 1967, to Chairman Mills.....	2411
Hursh, Morris, commissioner, Minnesota Department of Public Welfare, letter dated March 17, 1967, to Chairman Mills.....	2415
Hutton, William, executive officer, National Council of Senior Citizens, Appendix A—Extended care facility benefits.....	1368
Hyde, James F. C., Jr., national president, Blinded Veterans Association, statement.....	2225
Illinois Commission on Children, Miss Naomi Hiatt, executive director, letter dated March 9, 1967, to Chairman Mills.....	2416
Illinois Manufacturers' Association, statement.....	2121
Illinois State Chamber of Commerce, William H. Lowe, chairman, public assistance and welfare committee, Relief rolls or pay rolls? A searching look at public aid in Illinois and how it concerns every businessman.....	1875
Insurance company intermediaries (Aetna Life Insurance Co., etc.), Daniel W. Pettengill, vice president, Aetna Life & Casualty, notice of proposed rulemaking, health insurance program for the aged, from the Federal Register of February 7, 1964.....	454
International Association of Health Underwriters, Paul D. Hill, CLU, chairman, legislative committee, statement.....	2453
International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America, Carlos Moore, legislative director, statement.....	2129
International Ladies' Garment Workers' Union, Louis Stulberg, president, statement.....	2131
International Longshoremen's & Warehousemen's Union, Louis Goldblatt, secretary-treasurer, statement.....	2131
Investors League, Inc., William Jackman, president, statement.....	2263
Iowa Mutual Tornado Insurance Association, Harry L. Gross, chairman of the board, letter dated April 18, 1967, to Chairman Mills.....	2251
Iowa Nursing Home Association, statement.....	2285
Ives, Robert M., president, Community Welfare Planning Association of Greater Houston, letter dated March 28, 1967, to Chairman Mills.....	2396

	Page
Izquierdo-Mora, Dr. Luis A. (<i>See</i> Puerto Rico Medical Association.)	
Jackman, William, president, Investors League, Inc., statement	2263
Jackson, Donald C., executive secretary, Texas Academy of General Practice, letter dated March 13, 1967, to Ways and Means Committee, with resolution attached	2304
Jacobs, Hon. Andrew, Jr., a Representative in Congress from the State of Indiana, letter dated March 24, 1967, to Chairman Mills	2078
Jenkins, Edith G., director, Transylvania County (N.C.) Department of Public Welfare, letter dated March 20, 1967, to Chairman Mills	2403
Jenkins, Thomas M., president, American Association of Homes for the Aging, telegram dated April 17, 1967, to Chairman Mills	1009
Jennings American Legion Hospital, Inc., Herschel N. Knight, attorney, letter dated March 8, 1967, to Congressman Hale Boggs	770
Jewish Counseling and Service Agency, Irving Greenberg, executive director, letter dated March 21, 1967, to Chairman Mills	2397
Jewish Family Service of Philadelphia, Mrs. Benjamin A. Gouley, president, letter dated March 29, 1967, to Chairman Mills	2414
Johnson, Norris O., professor of economics, New College, Sarasota, Fla., letter dated March 9, 1967, to Congressman A. S. Herlong, Jr. (forwarded by Congressman Herlong)	2067
Jorgensen, G., M.D., director, Bellevue Maternity Hospital, Schenectady, N. Y., letter dated March 7, 1967, to Chairman Mills	2282
Juvenile Welfare Board of Pinellas County, Fla., George H. Finck, director, statement	2386
Juras, Andrew F., administrator, Oregon State Public Welfare Commission, letter dated March 10, 1967, to Congressman Al Ullman	1191
Kentucky Department of Child Welfare, Maurice A. Harmon, commissioner, letter dated March 20, 1967, to Chairman Mills	2392
King, Raymond E., Jr. (<i>See</i> National Association of Life Underwriters.)	
King, Rueben H., commissioner, Alabama Department of Pensions and Security, letter dated April 11, 1967, to Chairman Mills	2369
Knapp Memorial Methodist Hospital, Weslaco, Tex., Charles L. Foster, Jr., administrator, letter dated March 22, 1967, to Senator Ralph Yarborough, with forwarding letter from E. (Kika) de la Garza, a Representative in Congress from the State of Texas	2284
Knight, Herschel N., attorney, Jennings American Legion Hospital, Inc., letter dated March 8, 1967, to Congressman Hale Boggs	770
Knowles, John H., M.D., general director, Massachusetts General Hospital, statement	2280
Koretz, Sidney, Arlington, Va., letters dated March 16, 1967 and March 17, 1967, with attachment, to Chairman Mills	2443
Kovac, George, president, Eastern Pennsylvania Occupational Therapy Association, letter dated March 27, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee	2356
Kupferman, Hon. Theodore R., a Representative in Congress from the State of New York:	
To remove the limitation upon the amount of outside income an individual may earn while receiving social security benefits (statement from Congressional Record of Feb. 1, 1967)	1412
Businessmen favor bill to change social security	1417
Life Begins at 40: Social security law ceiling on elders' earnings outdated	1413
Poll favors removing lid on earnings on elderly	1418
Problem of the elderly	1414
Social security changes desired	1415
Social security neither insurance nor apparently a bona fide premise	1415
Years alter views on social security (article)	1416
Lackawanna County, Pa.:	
Mellody, Patrick J., chairman of the board of commissioners, letter dated March 17, 1967, to Chairman Mills	2396
Rosenstein, Gene, chairman of the board, citizens advisory committee, Institution District, Bureau of Children's Services, letter dated March 16, 1967, to Chairman Mills	2395
Taylor, Norman J., executive director, Welfare Planning Council, letter dated March 17, 1967, to Chairman Mills	2404

	Page
Landauer, Anni, Washington, D.C., letter dated April 4, 1967, to Chairman Mills-----	2450
Lanham, Richard, H., Jr., D.S.C., American College of Foot Orthopedists, letter dated March 7, 1967, to Chairman Mills-----	2351
Lazaro, Philip K., director, Essex County (N.J.) Welfare Board, letter dated April 11, 1967, to Chairman Mills-----	1263
Lee, Donald C., president, Maryland Conference of Social Welfare, letter dated March 14, 1967, to Congressman George H. Fallon, with forwarding letter-----	2394
Life Insurance Association of America. (See Young, George W.)	
Life Insurers Conference, Martin B. Williams, executive vice president and treasurer, letter dated March 27, 1967, to Chairman Mills-----	1228
Linford, Alton A., dean, School of Social Service Administration, University of Chicago, letter dated March 7, 1967, to Chairman Mills-----	2408
Lipton, Joseph M., president, Greater Miami Jewish Federation, letter dated March 24, 1967, to Chairman Mills-----	2380
Lloyd, Thomas J., international president, and Patrick E. Gorman, secretary-treasurer, Amalgamated Meat Cutters & Butcher Workmen of North America, letter dated April 5, 1967, to Chairman Mills-----	
Locher, Ralph S., mayor, city of Cleveland, letter dated April 6, 1967, to Chairman Mills-----	2066
Long, G. C., Jr., executive director, Alabama Hospital Association, letter dated March 16, 1967, to Chairman Mills-----	2281
Los Angeles, County of:	
Board of Supervisors, James S. Mize, clerk, letter dated April 14, 1967, to National Association of Counties-----	1795
Department of Public Social Services, Ellis P. Murphy, director, letter dated March 14, 1967, to Chairman Mills-----	2415
Loucks, William D. Jr., Esq., New York, N.Y., letter dated March 7, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee-----	2433
Louisiana Hospital Association, New Orleans district, Fred Willie, president, telegram dated March 16, 1967, to Chairman Mills-----	2283
Louisiana State Medical Society:	
Sabatier, J. A., Jr., M.D., president, letter dated April 21, 1967, to Chairman Mills-----	2297
Smith, F. Michael, Jr., M.D., technical adviser to the LSMFP, letters dated February 27, 1967, and March 9, 1967, to Chairman Mills----	2298
Lowe, William H., chairman, public assistance and welfare committee, Illinois State Chamber of Commerce, relief rolls or pay rolls? A searching look at public aid in Illinois and how it concerns every businessman----	1875
Luebs, Harold W., chairman, accounting and statistical committee, South Western Pennsylvania Chapter, American Association of Hospital Accountants, letter dated March 17, 1967, to Leo Irwin, chief counsel, Ways and Means Committee-----	2251
McAvoy, Harold, national president, National Association of Post Office Mail Handlers, Watchmen, Messengers & Group Leaders, AFL-CIO, statement-----	2257
McGrary, Mrs. Barbara D. (See American Parents Committee.)	
McKeldin, Theodore R., mayor, city of Baltimore, statement-----	2358
McKenna, Kathryn S., regional supervisor, Office for Children and Youth, Pennsylvania Department of Public Welfare, letter dated March 17, 1967, to Chairman Mills-----	2395
McManus, John E., president, New England Association of Child Care Personnel, letter dated March 24, 1967, to Chairman Mills-----	2386
McMillan, John J., administrative officer, State and professional affairs, American Psychological Association, letter dated April 12, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee-----	1048
McNerney, Walter J. (See Blue Cross Association.)	
McNeil, C. F. (See National Social Welfare Assembly, Inc.)	
McPheeters, Harold L., M.D., associate director, mental training and research, Southern Regional Education Board, statement-----	2405
MacDougall, William R., secretary, committee on welfare, National Association of Counties, additional recommendations relating to H.R. 5710-----	1787
Machinery & Allied Products Institute, Charles W. Stewart, president, letter dated March 31, 1967, to Chairman Mills, with attachment-----	2091

	Page
Macomb Clinical Laboratory, Gilbert E. Zook, letter dated March 18, 1967, to Chairman Mills-----	1056
Maiella, Helen M., recording secretary, Rhode Island State Circle, Daughters of Isabella, letter dated March 11, 1967, to Chairman Mills, with resolution attached-----	2419
Mandigo, Helen J., president, American Home Economics Association, telegram dated March 21, 1967, to Chairman Mills-----	2399
Mantler, Marshall J., executive director, Bureau of Salesmen's National Associations, statement-----	2111
Manufacturers Association of Syracuse (N.Y.), statement-----	2124
Marin, Rosa C., D.S.W., professor and director of the school, School of Social Work, College of Social Sciences, University of Puerto Rico, Letter dated March 10, 1967, to Chairman Mills-----	2410
Martin, Stephen I., assistant general counsel, National Association of Independent Insurers, statement-----	2245
Maruyama, George M., M.S., president, American Association of Bioanalysts, letter dated March 6, 1967, to Chairman Mills-----	1055
Maryland Conference of Social Welfare, Donald C. Lee, president, letter dated March 14, 1967, to Congressman George H. Fallon, with forwarding letter-----	2394
Maryland Department of Public Welfare, Raleigh C. Hobson, director, letter dated March 13, 1967, to Congressman George H. Fallon, with forwarding letter-----	2393
Maryland Nurses Association, Alice M. Sundberg, R.N., president, letter dated April 13, 1967, to Chairman Mills-----	2230
Maryland Occupational Therapy Association, Maurice S. Brubaker, president, letter dated April 18, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee-----	2355
Masons, Conference of Grand Masters of, in North America:	
Bridwell, Joseph L., grand master of Masons in the State of Indiana, letter dated March 20, 1967, with 17 exhibits, to Chairman Mills--	2145
Hockstad, Robert A., chairman, and grand master of Masons in the State of Michigan, letter dated March 15, 1967, to Chairman Mills--	2142
Massachusetts Department of Public Welfare, Robert F. Ott, Commissioner, letter with attachment, dated April 7, 1967, to Congresswoman Margaret Heckler, with forwarding letter-----	2080
Massachusetts General Hospital, John H. Knowles, M.D., general director, statement-----	2280
Massachusetts Medical Society, William W. Babson, M.D., president, letter dated March 8, 1967, to Chairman Mills-----	2301
Massachusetts Society for the Prevention of Cruelty to Children, Robert M. Mulford, general secretary, letter dated March 2, 1967, to Chairman Mills-----	2394
Meany, George, president, American Federation of Labor and Congress of Industrial Organizations (AFL-CIO):	
Background statement on social security and welfare by AFL-CIO department of social security-----	587
Old-age, survivors and disability and "Medicare," adopted December 1965 by the sixth constitutional convention, AFL-CIO-----	592
Statement by the AFL-CIO executive council on social security and welfare, February 20, 1967, Bal Harbour, Fla-----	586
Medical School Pediatric Department. (See Dr. Ralph Wedgwood.)	
Medina, Dr. Cesar A., president, Colegio de Cirujanos Dentistas de P.R., and Puerto Rico Dental Association, letter to Chairman Mills, with statement-----	1639-j
Mellody, Patrick J., chairman of the board, Lackawanna County (Pa.) Commissioners, letter dated March 17, 1967, to Chairman Mills-----	2396
Mendelson, Mary Adelaide, associate executive secretary, Welfare Federation of Cleveland, addendum to statement-----	865
Meredith, L. C., M.D., president, Ohio State Medical Association, letter dated March 31, 1967, to Congressman Jackson E. Betts, with attached exhibits-----	1683
Mergele, Dr. Marvin E., Houston, Tex., letter dated March 17, 1967, to Congressman George Bush-----	1074

	Page
Merrill, Charles, chairman, congressional action committee, Greater Syracuse Chamber of Commerce, Inc., letter dated March 21, 1967, to Chairman Mills with statement of Richard T. Hughes, member, attached.....	2125
Mers, Wm. H., & Co., Frederic A. Powers, C.P.A., letter dated March 20, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee.....	2429
Messner, Sherwood A., director, services section, medical and scientific department, United Cerebral Palsy Associations, Inc., statement.....	2236
Methodist Church, Richard P. Edgar, director, department of social welfare, general board of Christian social concerns, statement.....	1272
Miami, Greater, Jewish Federation, Joseph M. Lipton, president, letter dated March 24, 1967, to Chairman Mills.....	2380
Minnesota Department of Public Welfare, Morris Hursh, commissioner, letter dated March 17, 1967, to Chairman Mills.....	2415
Missouri Occupational Therapy Association, Avise M. Haines, chairman, legislative committee, letter dated March 30, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee.....	2355
Mitchell, Clarence, director, Washington bureau, National Association for the Advancement of Colored People, letter dated April 6, 1967, to Chairman Mills.....	2234
Mize, James S., clerk, board of supervisors, County of Los Angeles, letter dated April 14, 1967, to National Association of Counties.....	1795
Moore, Carlos, legislative director, International Brotherhood of Teamsters, Chauffeurs, Warehousemen & Helpers of America, statement.....	2129
Moore, William G., M.D., LaPorte, Ind., letter dated March 21, 1967, to Chairman Mills.....	2338
Morgan, George D., Lansdowne, Pa., statement.....	2449
Morris, Stephen J. (See American Nursing Home Association.)	
Mowbray, Dr. Douglas T., president, American Podiatry Association, payment for podiatrists' services under supplementary medical insurance program (H. Rept. 2300, 89th Cong., second sess.).....	1139
Mudge, John T., C.P.P., Mercer Island, Wash., letter dated March 15, 1967, to Chairman Mills.....	2434
Mueller, William J. (See American Hospital Association.)	
Mulford, Robert M., general secretary, Massachusetts Society for the Prevention of Cruelty to Children, letter dated March 2, 1967, to Chairman Mills.....	2394
Murphy, Ellis P., director, department of public social services, County of Los Angeles, letter dated March 14, 1967, to Chairman Mills.....	2415
Murphy, Miss Mary-Alice, president, Florida Occupational Therapy Association, letter dated April 3, 1967, to Leo H. Irwin, chief council, Ways and Means Committee.....	2354
Nassau Diagnostic Laboratory, Far Rockaway, N.Y., Harry Ronis, director, letter dated March 15, 1967, to Chairman Mills.....	2296
National Association for the Advancement of Colored People, Clarence Mitchell, director, Washington bureau, letter dated April 6, 1967, to Chairman Mills.....	2234
National Association for Retarded Children, statement.....	2230
National Association of Blue Shield Plans, A review of Social Security Administration's comments on the testimony of medicare part B carriers.....	554
National Association of Counties, William R. MacDougall, secretary, committee on welfare, additional recommendations relating to H.R. 5710.....	1787
National Association of Independent Insurers, Stephen I. Martin, assistant general counsel, statement.....	2245
National Association of Life Underwriters:	
Douds, H. James, general counsel, and David J. Pattison, assistant general counsel, letter dated April 7, 1967, to Chairman Mills, with attachment.....	1237
King, Raymond E., Jr., chairman, committee on social security, letter dated April 7, 1967, to Chairman Mills from H. James Douds, general counsel, and David J. Pattison, assistant general counsel, with attached table entitled "Monthly Retirement Benefits Available From Representative Commercial Insurers for \$315 per Annum Compared With Increases in Monthly Social Security Benefits Provided by a Like Tax Increase".....	1237

	Page
National Association of Manufacturers, statement.....	2085
National Association of Post Office Mail Handlers, Watchmen, Messengers & Group Leaders, AFL-CIO, Harold McAvoy, national president, statement.....	2257
National Association of Retired Civil Employees, Clarence M. Tarr, president, statement.....	1616
National Association of Social Workers:	
Gonzalez, Elisa Diaz, acting president, Puerto Rico chapter, and Antonio S. Rodriguez, president, College of Social Workers of Puerto Rico, letter dated April 3, 1967, to Chairman Mills.....	2360
Schottland, Charles I., president, and Herman D. Stein, president, Council on Social Work Education, joint supplementary state- ment.....	1725
National Association of Social Workers, Inc.:	
Cowles, Robert, president, Southern Arizona Chapter, letter dated March 27, 1967, to Chairman Mills.....	2399
Negrón, Héctor R., president, Puerto Rico Chapter, letter dated March 28, 1967, to Chairman Mills with resolution attached....	2364
National Association of State Mental Health Program Directors:	
Ganser, Dr. Leonard, vice president:	
Federal money distribution to public and private psychiatric hospitals (table).....	1085
Title IV.—Aid to families of dependent children (table).....	1086
Title X.—Aid to the blind (table).....	1086
Title XIV.—Aid to the permanently and totally disabled (table).....	1086
Schumacher, William E., M.D., president, letter dated March 17, 1967, to Chairman Mills with attached amendment.....	1088
National Coal Association, Brice O'Brien, general counsel, letter dated March 13, 1967, to Chairman Mills.....	2120
National Congress of Parents and Teachers, Mrs. Edward F. Ryan, national PTA chairman for legislation, statement.....	2384
National Consumers League, statement.....	2118
National Council of Churches of Christ in the U.S.A., Arthur S. Flemming, president, a pronouncement—A policy statement of the National Council of the Churches of Christ in the U.S.A.:	
The churches' concern for public assistance.....	1277
The churches' concern for people without the necessities of life.....	1279
National Council of Jewish Women, Inc., statement.....	2240
National Council of Senior Citizens, William Hutton, executive officer, Appendix A—Extended care facility benefits.....	1368
National Council on Crime and Delinquency, Milton G. Rector, director, director, letters dated March 16 and April 5, 1967, to Chairman Mills..	2383
National Council on the Aging, statement.....	2372
National Federation of Federal Employees, Nathan T. Wolkomir, presi- dent, statement.....	2256
National Federation of Independent Business, George S. Bullen, legis- lative director, statement.....	2140
National Federation of Settlements and Neighborhood Centers, Gladys Duppstadt, staff member, statement.....	2399
National Grange, Harry L. Graham, legislative representative, letter dated April 11, 1967, to Chairman Mills.....	2115
National Paraplegia Foundation, James Smittkamp, executive director, letter dated March 14, 1967, to Congressman John B. Anderson.....	1772
National Postal Union, Sidney A. Goodman, president, statement.....	1615
National Restaurant Association, Ira H. Nunn, Washington, counsel, statement.....	2137
National Retail Merchants Association, James J. Bliss, executive vice president, statement.....	2116
National Rural Letter Carriers' Association, Carey W. Hilliard, president, letter dated March 8, 1967, to Chairman Mills.....	2257
National Small Business Association, Carl A. Beck, president, letter dated April 10, 1967, to Ways and Means Committee.....	2090

	Page
National Social Welfare Assembly, Miss Elizabeth Wickenden, technical consultant on public social policy:	
Letter dated March 30, 1967, to Chairman Mills, re supplementary statement of Rochester, N.Y., Council of Social Agencies, Kenneth Storandt, executive director-----	1606
Letter from C. F. McNeil, director, National Social Welfare Assembly, Inc., dated March 27, 1967, to Chairman Mills-----	1606
Letter from Mother M. Bernardine, administrator, Good Shepherd School for Girls, dated March 20, 1967-----	1603
"Having the Power, We Have the Duty"—the Advisory Council on Public Welfare, Report to the Secretary of Health, Education, and Welfare, etc-----	1591
National Townsend Plan, John Doyle Elliott:	
Article entitled "Poverty War Requires This Bill"-----	2039
Article entitled "Real Meaning of Gross Income Tax"-----	2042
Text of H.R. 5930, 90th Congress, first session, introduced by Mr. McFall on February 21, 1967-----	2029
National Tuberculosis Association, James E. Perkins, M.D., managing director, letter dated March 14, 1967, to Chairman Mills-----	2237
Negrón, Héctor R., president, Puerto Rico chapter, National Association of Social Workers, Inc., letter dated March 28, 1967, to Chairman Mills, with resolution attached-----	2364
Nelson & Warren, Inc., consulting actuaries, Carroll E. Nelson, letter dated March 9, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee-----	2255
Nelson-Jones, Richard, acting director, New England Board of Higher Education, telegram dated February 27, 1967, to chairman Mills, and letter dated March 22, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee-----	2404
New College, Sarasota, Fla., Norris O. Johnson, professor of economics, letter dated March 9, 1967, to Congressman A. S. Herlong, Jr. (forwarded by Congressman Herlong)-----	2067
New England Association of Child Care Personnel, John E. McManus, president, letter dated March 24, 1967, to Chairman Mills-----	2386
New England Board of Higher Education, Richard Nelson-Jones, acting director, telegram dated February 27, 1967, to Chairman Mills, and letter dated March 22, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee-----	2404
New York League of Business & Professional Women, Inc., Mrs. Ottilie Fiealt, statement-----	2381
New York Medical Society, Frederick A. Wurzbach, Jr., M.D., president, letter dated March 30, 1967, to Chairman Mills, with resolution attached-----	2297
New York State Occupational Therapy Association, Hattye M. Cleveland, chairman, legislation committee, letter dated April 4, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee-----	2356
New York University, School of Education, Frieda J. Behlen, O.T.R., associate professor of education, director, occupational therapy program, letter dated March 23, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee-----	2403
Newman, Wm. Kincaid, executive vice president, Annuity Fund for Congregational Ministers, letter dated March 29, 1967, to Chairman Mills-----	2357
North, William D., Esq., Kirkland, Ellis, Hodson, Chaffetz & Masters, letter dated March 14, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee-----	2430
Nunn, Ira H., Washington counsel, National Restaurant Association, statement-----	2137
O'Brien, Brice, general counsel, National Coal Association, letter dated March 13, 1967, to Chairman Mills-----	2120
Occupational Therapy Association. (See under State name).	
O'Donnell, Charles C. (See Senior Citizens & Associates of America.)	
Ohio State Medical Association, L. C. Meredith, M.D., president, letter dated March 31, 1967, to Congressman Jackson E. Betts, with attached exhibits-----	1683

	Page
Oregon State Public Welfare Commission, Andrew F. Juras, administrator, letter dated March 10, 1967, to Congressman Al Ullman.....	1191
Ostrander, Dr. F. Darl, president-elect, American Dental Association, Report on dental prepayment plans in the United States.....	1068
Ott, Robert F., Commissioner, Massachusetts department of Public Welfare, letter with attachment, dated April 7, 1967, to Congresswoman Margaret M. Heckler, with forwarding letter.....	2080
Packard, Arthur J., Sr., chairman, governmental affairs committee, American Hotel & Motel Association, statement.....	2135
Paralyzed Veterans of America, Howard L. Bennett, executive secretary, statement.....	2224
Patients' Aid Society, Inc., James F. Donnelly, president, statement.....	2338
Pattison, David J., assistant general counsel, and H. James Douds, general counsel, National Association of Life Underwriters, letter dated April 7, 1967, to Chairman Mills, with attachment.....	1237
Paulding Memorial Hospital, Dallas, Ga., William E. Elmore, administrator, letter dated February 20, 1967, to Leo Irwin, chief counsel, Ways and Means Committee.....	2284
Penn Mutual Life Insurance Co., William A. White, assistant actuary, letter dated March 30, 1967, to Chairman Mills.....	2249
Pennsylvania Department of Public Welfare, Office for Children and Youth, Kathryn S. McKenna, regional supervisor, letter dated March 17, 1967, to Chairman Mills.....	2395
Pennsylvania State University, College of Human Development, Donald H. Ford, dean, letter dated April 11, 1967, to Chairman Mills, with attached press release.....	2412
Pepper, Hon. Claude, a Representative in Congress from the State of Florida, supplemental statement entitled "Representative Claude Pepper's Social Security Program".....	1970
Perkins, James E. M.D., managing director, National Tuberculosis Association, letter dated March 14, 1967, to Chairman Mills.....	2237
Pettengill, Daniel W., vice president, Aetna Life & Casualty, in behalf of insurance company intermediaries (Aetna Life Insurance Co., etc.), notice of proposed rulemaking, health insurance program for the aged, from the Federal Register of February 7, 1967.....	454
Pickens, John K. (See American Nursing Home Association.)	
Planned Parenthood-World Population, Dr. Joseph Beasley, member of the board:	
Advance report, final natality statistics, 1965, from the National Center for Health Statistics.....	1516
Figure 1—Live births and fertility rates: United States, 1910-65.....	1517
Figure 2—Birth rates by age of mother: United States, 1940-65.....	1519
Table 1—Live births, birth rates, and fertility rates, by color: United States, 1950 and 1957-65.....	1520
Table 2—Live births by color, and birth rates, United States, each division and State, 1965.....	1520
Table 3—Births by age of mother, live birth order, and color: United States, 1965.....	1522
Table 4—Birth rates by age of mother, live birth, and color: United States, 1965.....	1523
Table 5—Live births by sex, and sex ratio at birth, by color: United States, 1950 and 1957-65.....	1523
Table 6—Birth rates, by age of mother, United States, 1940-65.....	1524
Table 7—Median weight and percent immature for live births, by color: United States, each division and States, 1965.....	1524
Polanco-Abreu, Hon. Santiago, Resident Commissioner of Puerto Rico, letter dated April 11, 1967, to Chairman Mills, enclosing copies of pertinent telegrams.....	1948
Powers, Frederic A., CPA, Wm. H. Mers & Co., letter dated March 20, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee.....	2429
Pratt, Charlotte R., chairman, committee on family and child welfare, department of public affairs, Community Service Society, letter dated April 5, 1967, to Chairman Mills, with enclosed letters dated April 4 and March 30, 1967.....	2364

	Page
Preininger, Rev. David R., program director, Bethesda United Presbyterian Church Community Center, letter dated March 15, 1967, to Congressman Elmer J. Holland, with forwarding letter-----	2414
Prettyman, E. Barrett, Jr., College of American Pathologists, statement to the Social Security Administration, Department of Health, Education, and Welfare on regulations governing hospital-based physicians, July 25, 1966 (placed in record by Congressman Byrnes)-----	1119
Prystowsky, Harry, M.D.: Association of Professors of Gynecology and Obstetrics, statement----	2431
Miller, J. Hillis, Health Center, College of Medicine, Department of Obstetrics and Gynecology, University of Florida, letter dated March 28, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee-----	2430
Puerto Rico, University of, College of Social Sciences, School of Social Work, Rosa C. Marin, D.S.W., professor and director of the school, letter dated March 10, 1967, to Chairman Mills-----	2410
Puerto Rico College of Pharmacy, Horacio R. Tous, B.S. Ph., president, letter dated April 19, 1967, to Chairman Mills-----	1640
Puerto Rico Dental Association and Colegio de Cirujanos Dentistas de P. R., Dr. Cesar A. Medina, president, letter to Chairman Mills, with statement-----	1639-j
Puerto Rico Hospital Association, Efraín Flores Gallardo, president, letter dated April 6, 1967, to Chariman Mills-----	2273
Puerto Rico Medical Association, Dr. Luis A. Izquierdo-Mora, president, and Dr. J. A. Alvarez-De Choudens, president-elect: Supplemental statement-----	1950
Free choice medical assistance in Puerto Rico under Title XIX—Public Law 89-97 for fiscal year 1969-1970 "Economic Feasibility Study" with addendum-----	1639
Purdy, Joseph H., president, Health and Welfare Council of the Baltimore Area, Inc., letter dated April 21, 1967, to Chairman Mills-----	2417
Queenan, John W., managing partner, Hasking & Sells, certified public accountants, letter dated March 17, 1967, to Chairman Mills-----	2253
Railway Labor Executives' Association, Donald S. Beattie, executive secretary, letter dated April 7, 1967, to Chairman Mills-----	601
Ramsey County, Minn., Welfare Department, county welfare board, S. S. Grais, chairman, letter dated March 15, 1967, to Chairman Mills, with attachment-----	2426
Rector, Milton G., director, National Council on Crime and Delinquency, letters dated March 16 and April 5, 1967 to Chairman Mills-----	2383
Reilly, Carl N., M.D., secretary, Charlotte County, Fla., Medical Society letter dated March 20, 1967, to Chairman Mills, with statement attached-----	2302
Retired Officers Association, James W. Chapman, Colonel, USAF, Retired, legislative counsel, letter dated April 18, 1967, to Chairman Mills----	2214
Reuther, Walter P. (See United Auto Workers of America.)	
Rhode Island Department of Social Welfare, Augustine W. Riccio, director, letter dated March 27, 1967, to Chairman Mills-----	1090
Rhode Island State Circle, Daughters of Isabella, Helen M. Maiella, recording secretary, letter dated March 11, 1967 to Chairman Mills, with resolution attached-----	2419
Riccio, Augustine W., director, Rhode Island Department of Social Welfare, letter dated March 27, 1967, to Chairman Mills-----	1090
Robinson, John. (See Citizens Committee for Responsible Government.)	
Rochester, N.Y., Council of Social Agencies, Kenneth Storandt, executive director, statement, submitted in letter dated March 30, 1967, to Chairman Mills, from Elizabeth Wickenden, National Social Welfare Assembly, Inc-----	1606
Rodriguez, Antonio S., president, College of Social Workers of Puerto Rico, and Elsa Diaz Gonzalez, acting president, Puerto Rico chapter, National Association of Social Workers, letter dated April 3, 1967, to Chairman Mills-----	2360
Ronis, Harry, director, Nassau Diagnostic Laboratory, Far Rockaway, N.Y., letter dated March 15, 1967, to Chairman Mills-----	2296
Rosenstein, Gene, chairman of the board, Citizens Advisory Committee, Bureau of Children's Services, Lackawanna County, Pa., institution district, letter dated March 16, 1967, to Chairman Mills-----	2395

	Page
Rutgers University, Graduate School of Social Work, Werner W. Boehm, dean, letter dated March 15, 1967, to Chairman Mills.....	2410
Ryan, Mrs. Edward F., national PTA chairman for legislation, National Congress of Parents and Teachers, statement.....	2384
St. Onge, Hon. Willima L., a Representative in Congress from the State of Connecticut, statement.....	2068
Sabatier, J. A., Jr., M.D., president, Louisiana State Medical Society, letter dated April 21, 1967, to Chairman Mills.....	2297
Sanford, Mrs. W. R., chairman, legislation, Colorado Parent-Teachers, Association, statement.....	2397
Schatz, Dora N., president, Senior Citizens Central Association, letter dated March 17, 1967, to Chairman Mills with resolution attached....	2377
Schloss, Irvin P., legislative analyst, American Foundation for the Blind, Inc., statement.....	2241
Schmidt, Wilbur J. (<i>See</i> American Public Welfare Association.)	
Schmidt, William M., M.D., professor of maternal and child health and head of department, School of Public Health, Harvard University, letter dated March 28, 1967, to Chairman Mills.....	2269
Schottland, Charles I., president, National Association of Social Workers, and Herman D. Stein, president, Council on Social Work Education, joint supplementary statement.....	1725
Schreiber, Jack, M.D., Canfield, Ohio, letter dated March 21, 1967, to Chairman Mills, with attachment.....	2336
Schuman, Irving, M.D., president, Society for Pediatric Research, telegram dated March 13, 1967, to Chairman Mills.....	1192
Schumacher, William E., M.D., president, National Association of State Mental Health Program Directors, letter dated March 17, 1967, to Chairman Mills with attached amendment.....	1088
Schweiker, Hon. Richard S., a Representative in Congress from the State of Pennsylvania:	
Letter dated January 31, 1967, to Hon. John W. Gardner, Secretary, HEW.....	567
Letter dated February 27, 1967, from Wilbur J. Cohen, Acting Secretary, HEW.....	568
Report on processing of medicare claims in Pennsylvania, from Robert M. Ball, Commissioner of Social Security.....	569
Senior Citizens, Inc., Mrs. Grace Taylor, president, members' council, letter dated March 17, 1967, to Leo Irwin, chief counsel, Ways and Means Committee.....	2377
Senior Citizens & Associates of America, Charles C. O'Donnell, executive director:	
Resolutions requesting Congress to call a convention for proposing an amendment to the Constitution of the United States providing a pension of \$200 monthly for certain persons.....	1377
Article entitled "You Didn't Know, but It's Your Day in the Sunday Post".....	1378
Senior Citizens Central Association, Dora N. Schatz, president, letter dated March 17, 1967, to Chairman Mills with resolution attached..	2377
Shake, Randel, director, national child welfare division, American Legion, statement.....	2214
Shaperman, Julie, president, Southern California Occupational Therapy Association, Inc., letter dated March 29, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee.....	2354
Shapira, Saul F., president, Health and Welfare Association of Allegheny County (Pa.), letter dated March 31, 1967, to Chairman Mills.....	2417
Shelmire, Maria E., executive director, Family Service of Delaware County (Pa.), letter dated March 30, 1967, to Chairman Mills.....	2411
Sibley, Hiram, executive director, Hospital Planning Council for Metropolitan Chicago, letter dated April 4, 1967, to Congressman Frank Annunzio, with attachment, with forwarding letter.....	2275
Siegfried, Charles A. (<i>See</i> Health Insurance Association of America.)	
Sixty Now, Inc., statement.....	2373
Slowinski, Eugene J., M.D., professor and chairman, Department of Obstetrics and Gynecology, School of Medicine, Creighton University, letter dated March 17, 1967, to Leo Irwin, chief counsel, Ways and Means Committee.....	2418

	Page
Smith, F. Michael, Jr., M.D., technical adviser to the LSMFP, Louisiana State Medical Society, letters dated February 27, 1967, and March 9, 1967, to Chairman Mills-----	2298
Smith, Marvin. (<i>See American Nursing Home Association.</i>)	
Smith, Ronald B., Providence, R.I., letter dated March 20, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee-----	2436
Smittkamp, James, executive director, National Paraplegia Foundation, letter dated March 14, 1967, to Congressman John B. Anderson-----	1772
Society for Pediatric Research, Irving Schulman, M.D., president, telegram dated March 13, 1967, to Chairman Mills-----	1192
Somers, Edmond L., Allentown, Pa., letter dated March 4, 1967, to Congressman Fred B. Rooney, with forwarding letter-----	2440
Southern California Occupational Therapy Association, Inc., Julie Shaperman, president, letter dated March 29, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee-----	2354
Southern California Pharmaceutical Association, Ltd., David W. Fleming, legal counsel, statement-----	1696
Southern Regional Education Board, Harold L. McPheeters, M.D., associate director, mental training and research, statement-----	2405
Southwestern Clinic Hospital, Inc., Lawton, Okla., Karey Fuqua, administrator, letter dated March 14, 1967, to Chairman Mills-----	2283
Sox, Ellis D., M.D., president, U.S. Conference of City Health Officers, and U.S. Conference of Mayors, statement-----	2082
Stanton, James V., president, Cleveland City Council, letter to Chairman Mills-----	2066
Stein, Dr. Herman D. (<i>See Council on Social Work Education.</i>)	
Stephens, Nell May F., Washington, D.C., letter dated April 11, 1967, to Committee on Ways and Means-----	2452
Stewart, Charles W., president, Machinery and Allied Products Institute, letter dated March 31, 1967, to Chairman Mills, with attachment-----	2091
Stokes, J. Boroughs, manager, Washington, D.C., office, Christian Science Committee on Publication, First Church of Christ, Scientist, letter dated March 21, 1967, to Chairman Mills-----	2371
Storandt, Kenneth, executive director, Rochester, New York, Council of Social Agencies, statement, submitted in letter dated March 30, 1967, to Chairman Mills from Elizabeth Wickenden, National Social Welfare Assembly, Inc-----	1606
Stover, Francis W., director, national legislative service, Veterans of Foreign Wars of the United States, letter dated April 3, 1967, to Chairman Mills-----	2223
Stratton, Hon. Samuel S., a Representative in Congress from the State of New York:	
Resolutions:	
Cayuga County Board of Supervisors, dated February 21, 1967--	1960
Montgomery County Board of Supervisors, dated December 13, 1966, and March 14, 1967-----	1958
Ontario County Board of Supervisors, dated March 22, 1967----	1960
Supervisors' Association of the State of New York, Inc., organized for the safeguard and improvement of local government-----	1958
Stringer, Herald E., director, legislative commission, the American Legion, letter dated April 24, 1967, to Chairman Mills, with statement of John J. Corcoran, director, national rehabilitation commission, attached-----	2222
Stulberg, Louis, president, International Ladies' Garment Workers' Union statement-----	2131
Sundberg, Alice M., R. N., president, Maryland Nurses Association, letter dated April 13, 1967, to Chairman Mills-----	2230
Syracuse Chamber of Commerce, Inc., Greater, Charles Merrill, chairman, congressional action committee, letter dated March 21, 1967, to Chairman Mills with statement of Richard T. Hughes, member, attached-----	2125
Tarr, Clarence M., president, National Association of Retired Civil Employees, statement-----	1616
Taylor, Mrs. Grace, president, members' council, Senior Citizens, Inc., letter dated March 17, 1967, to Leo Irwin, chief counsel, Ways and Means Committee-----	2377

	Page
Taylor, Norman J., executive director, Welfare Planning Council of Lackawanna County (Pa.), letter dated March 17, 1967, to Chairman Mills.....	2404
Terrebonne Parrish (La.) Medical Society, Dr. T. A. Gross, president, letter dated March 30, 1967, to Chairman Mills.....	2300
Terris, Dr. Milton, president, American Public Health Association, letter dated April 5, 1967, to Chairman Mills.....	1137
Texas Academy of General Practice, Donald C. Jackson, executive secretary, letter dated March 13, 1967, to Ways and Means Committee, with resolution attached.....	2304
Thomas, R. Edward, M.D., Irving, Tex., letter dated March 20, 1967, to Congressman Earl Cabell, with forwarding letter from Congressman Joe Pool.....	2077
Tompkins, Harvey, J., M.D., president, American Psychiatric Association, letter dated April 12, 1967, to Chairman Mills.....	1089
Toole, County (Utah) Department of Public Welfare, Mrs. Margaret Hood, director, letter dated March 17, 1967, to Chairman Mills.....	2411
Tous, Horacio R., B. S. Ph., president, Puerto Rico College of Pharmacy, letter dated April 19, 1967, to Chairman Mills.....	1640
Transylvania County (N.C.) Department of Public Welfare, Edith G. Jenkins, director, letter dated March 20, 1967, to Chairman Mills.....	2403
Travis, John W., M.D., chairman, committee on legislation and public relations, Kansas Radiological Society, Kansas Chapter, American College of Radiology, letter dated March 4, 1967, to Congressman Chester L. Mize, with forwarding letter, and letter dated March 15, 1967, Chairman Mills.....	2341
Tromly, R. G., M.D., Dallas, Tex., letter dated March 21, 1967, to Congressman Joe Pool, with forwarding letter.....	2077
United Auto Workers of America, Walter P. Reuther, president: Income maintenance (resolution adopted December 1966 by the executive board of the industrial union department).....	1450
Letter dated April 10, 1967, to Chairman Mills, providing additional information requested by committee.....	1471
Press release dated Wednesday, March 22, 1967, from UAW Washington office.....	1451
United Cerebral Palsy Associations, Inc., Sherwood A. Messner, director, services section, medical and scientific department, statement.....	2236
United Church of Christ, council for Christian social action, statement.....	1274
United Good Neighbors, H. G. "Bud" Horn, president, letter dated March 24, 1967, to Chairman Mills.....	2386
United States Conference of City Health Officers, Ellis D. Sox, M.D., president, statement.....	2082
United States Conference of Mayors, Ellis D. Sox, M.D., statement.....	2082
United Steelworkers of America District 20 (Pennsylvania), Michael J. Zahorsky, exhibits 1 through 12.....	647
Venable, John H., M.D., president, Association of State and Territorial Health Officers, letter dated April 5, 1967, to Chairman Mills.....	2263
Veterans of Foreign Wars of the United States, Francis W. Stover, director, national legislative service, letter dated April 3, 1967, to Chairman Mills.....	2223
Vincent, L. L., commissioner, West Virginia Department of Welfare, letter dated March 17, 1967, to Chairman Mills, with attachments.....	2420
Walker, Hon. E. S. Johnny, a Representative in Congress from the State of New Mexico, letter dated March 8, 1967 to Chairman Mills.....	2080
Washington National Insurance Co., Duane E. Williams, assistant general counsel, letter dated April 4, 1967, to Chairman Mills.....	2250
Wedgwood, Dr. Ralph, professor and chairman, Department of Pediatrics, School of Medicine, University of Washington, letter dated March 23, 1967, to Congressman Al Ullman.....	1186
Weissinger, Bob, president, board of directors, Family Counseling and Children's Services, letter dated March 29, 1967, to Chairman Mills.....	2384
Welfare Federation of Cleveland, Mary Adelaide Mendelson, associate executive secretary, addendum to statement.....	865
West Virginia Department of Welfare, L. L. Vincent, commissioner, letter dated March 17, 1967, to Chairman Mills, with attachments.....	2420
Westby, Frithjof, O.M., chairman, Department of Sociology and Social Work, Augustana College, letter dated March 28, 1967, to Chairman Mills.....	2407

	Page
Western Interstate Commission for Higher Education, Raymond Feldman, M.D., associate director, regional programs (mental health), statement.	2406
White, William A., assistant actuary, Penn Mutual Life Insurance Co., letter dated March 30, 1967, to Chairman Mills.	2249
Wickenden, Miss Elizabeth. (<i>See</i> National Social Welfare Assembly.)	
Williams, Duane E., assistant general counsel, Washington National Insurance Co., letter dated April 4, 1967, to Chairman Mills.	2250
Williams, Martin B., executive vice president and treasurer, Life Insurers Conference, letter dated March 27, 1967, to Chairman Mills.	1228
Williamson, Kenneth. (<i>See</i> American Hospital Association.)	
Willie, Fred, president, New Orleans District, Louisiana Hospital Association, telegram dated March 16, 1967, to Chairman Mills.	2283
Wisconsin Association of Nursing Homes, Inc., Thomas J. Bergen, executive secretary and legal counsel, statement.	2286
Wolkomir, Nathan T., president, National Federation of Federal Employees, statement.	2256
Wood, Clifford M., C.P.A., Bay Minette, Ala., letter dated March 6, 1967, to Leo H. Irwin, chief counsel, Ways and Means Committee.	2438
Wright, Samuel D., member of the New York State Assembly, letter dated March 2, 1967, to Chairman Mills.	2398
Wurzbach, Frederick A., Jr., M.D., president, New York Medical Society, letter dated March 30, 1967, to Chairman Mills, with resolution attached.	2297
Yale University, School of Medicine, Charles D. Cook, M.D., professor of pediatrics and chairman, Department of Pediatrics, letter dated March 13, 1967, to Chairman Mills.	2398
Young, George W., chairman, joint social security committee, American Life Convention, and Life Insurance Association of America:	
Exhibit I—The need for a vigorous increase in saving through private pension funds to aid in financing sound growth of the U.S. economy.	1218
Exhibit II—Comparison of average monthly benefits in current payment status to retired workers in actual dollars and in terms of 1965 purchasing power, December 1940-65.	1221
Exhibit III—Comparison of accumulated taxes and value of retirement benefits for employees within the next 20 years under the current law and the proposed law.	1222
Exhibit IV—Proportion of workers with total earnings covered by wage base and proportion of total earnings in covered employment taxable in selected years.	1222
Exhibit V—Proposed benefit increases for workers earning wages equal to or more than the then current wage base.	1222
Exhibit VI—Tax treatment of the aged (title V).	1223
Table 1—Social security earnings base and median wages.	1217
Zahorsky, Michael J., United Steelworkers of America, District 20 (Pennsylvania), exhibits 1 through 12.	647
Zelenka, Frank G., assistant executive director, American Nursing Home Association, letter dated May 8, 1967, to Congressman Al Ullman, Ways and Means Committee, with attachments re total number of extended care facilities certified for medicare, some figures relating to nursing home construction, and an index of the difference between the ordinary charges and the approved reimbursement.	830
Zook, Gilbert E., Macomb Clinical Laboratory, letter dated March 18, 1967, to Chairman Mills.	1056

PRESIDENT'S PROPOSALS FOR REVISION IN THE SOCIAL SECURITY SYSTEM

MONDAY, MARCH 6, 1967

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met pursuant to notice at 10 a.m. in the committee room, Longworth House Office Building, Hon. Wilbur D. Mills (chairman of the committee) presiding.

The CHAIRMAN. The committee will please be in order.

(The following report on H.R. 5710 was submitted to the committee by Hon. John W. Macy, Jr., chairman of the U.S. Civil Service Commission.)

U.S. CIVIL SERVICE COMMISSION,
Washington, D.C., April 19, 1967.

Hon. WILBUR D. MILLS,
*Chairman, Committee on Ways and Means,
House of Representatives.*

DEAR MR. CHAIRMAN: This letter is in response to your oral request for an expression of Commission views on those provisions of H.R. 5710, a bill "To Amend the Social Security Act * * *", that relate to transfer of Federal employment credits to the social security system.

So far as the civil service retirement system is concerned, these provisions, carried in section 116 of your bill, will—

permit the basic pay of a Federal employee under the civil service retirement system to be considered remuneration for employment for OASDI purposes if neither the employee nor any of his survivors is entitled to a civil service annuity on the basis of such service. The provision would not apply to service before June 30, 1966, or to service that terminated before the second month following enactment.

require the Chairman of the Civil Service Commission to furnish the Secretary of Health, Education, and Welfare, upon his request, a record of the service and pay of any such individual.

direct the Secretary of the Treasury to transfer from the Civil Service Retirement and Disability Fund to three of the social security trust funds (The Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and the Federal Hospital Insurance Trust Fund), annually, an amount sufficient to cover that proportion of the cost of *all* benefits paid from the three social security trust funds during the year which is attributable to Federal employment under the retirement system, plus interest from the date of such payment.

provide a formula for determining the proportion of the cost to be borne by the Civil Service Retirement and Disability Fund. For any one case, this proportion of the old-age, disability, survivor's, hospital insurance or other benefit is in the same ratio as the remuneration for Federal employment bears to the total remuneration for Federal plus other employment.

This legislation, if enacted, would assure Federal employees who leave the service without entitlement to retirement system annuity benefits, and those who lose such entitlement, that their service can be credited for social security

and hospital insurance purposes and thereby give them continuity of basic protection comparable to that afforded those who work, and move from one job to another, in private industry. We support that objective and the proposed method of obtaining it. Companion legislation which would amend the civil service retirement law and which is needed to implement the objective has already been introduced in both houses and referred to the respective Committees on Post Office and Civil Service. I have already testified in support of the bill H.R. 6784, and will similarly support the bill S. 1383. The Commission now urges favorable action on those provisions of your bill which deal with the subject.

The transfer-of-credit proposal is one half of a two-pronged proposal—recommended to the President by his Cabinet Committee on Federal Staff Retirement Systems and endorsed by him in his last year's pay message, his January 23 message on Older Americans, and his budget message—designed to assure that employees subject to the civil service retirement system have a level of protection at least as high as that which the social security system affords the rest of the nation's workforce. The other half of the proposal is a guaranteed benefit applicable only to persons who are entitled to benefits under the civil service retirement system. Under that part of the proposal, retirement system benefits would be raised to the extent necessary to assure that such benefits, together with any OASDI benefits based on other work, will at least equal the amount that would be payable to retirement system beneficiaries if the Federal service had been covered by social security. The benefit levels which would be guaranteed are the ultimate levels proposed by H.R. 5710 for future beneficiaries of the social security system.

We understand that all transfers of credit from the civil service retirement system to the social security system would be made at the time the risk matures, e.g. at the time the employee dies, becomes disabled, or reaches social security retirement age without protection under the retirement system. Employees would thereby acquire social security protection, and would be treated as social security beneficiaries, exactly as if their Federal service had actually been under social security.

The retirement system would refund retirement contributions to employees (or their survivors) only to the extent that such contributions exceed the OASDI and Hospital Insurance tax the employees would have paid after June 30, 1966, if their Federal service after that date had been covered by social security. This "tax equivalent" would be deducted from refunds irrespective of whether social security benefits are or will be payable and of whether OASDI and Hospital Insurance taxes are being paid on earnings from other employment. We estimate the level annual cost of this portion of the proposal at \$155 million, over and above the tax equivalents deducted from refunds. A part of this cost would be a proportionate reimbursement for benefits paid from the three social security trust funds in individual cases in which those benefits were not dependent on or increased by transferred wage credits.

Adoption of the recommended two-pronged approach would—without disturbing current benefit rights of present employees and without changing the retirement system's present independent status—meet to a large extent the needs for basic protection that are not now being met by the civil service retirement system. We urge that Congress act favorably on legislation to assure that those needs are met.

The Bureau of the Budget advises that from the standpoint of the Administration's program there is no objection to the submission of this report.

By direction of the Commission.

Sincerely yours,

JOHN W. MACY, Jr., *Chairman.*

The CHAIRMAN. Our first witness this morning is Mr. Daniel W. Pettengill. Mr. Pettengill, will you please come forward, sir? I understand you have some others who will sit with you at the table. Mr. White, Mr. Hanna, and Mr. Hawkins.

STATEMENT OF DANIEL W. PETTENGILL, VICE PRESIDENT, AETNA LIFE & CASUALTY, ON BEHALF OF THE INSURANCE COMPANY INTERMEDIARIES, ACCOMPANIED BY WILLIAM WHITE, PRUDENTIAL INSURANCE CO. OF AMERICA; ARTHUR E. HANNA, NATIONWIDE MUTUAL INSURANCE CO.; AND PAUL M. HAWKINS, WASHINGTON COUNSEL, HEALTH INSURANCE ASSOCIATION OF AMERICA

The CHAIRMAN. Mr. Pettengill, you have been before the committee on many occasions, but for purposes of this record will you again identify yourself.

Mr. PETTENGILL. I will, Mr. Chairman, and those at the table with me.

The CHAIRMAN. And those at the table with you.

Mr. PETTENGILL. I am Dan Pettengill and I have with me on my right Mr. William White, director of industry relations of the Prudential, and to my immediate left Paul Hawkins, Washington counsel of the Health Insurance Association of America and to his left Mr. Arthur E. Hanna, life and health associate of Nationwide.

I am vice president, group division, Aetna Life and Casualty. In each of the Secretary's contracts with the carriers and fiscal intermediaries, there is a provision for prior consultation on proposed regulations and general instructions through representative groups of the carriers and fiscal intermediaries.

I am privileged to serve as cochairman of the Carrier Representative Group and as a member of the Fiscal Intermediary Representative Group.

I appear before you today on behalf of the following insurance companies: Aetna Life Insurance Co.; the Travelers Insurance Co.; Mutual of Omaha Insurance Co.; the Prudential Insurance Co. of America; Nationwide Mutual Insurance Co.; Connecticut General Life Insurance Co.; John Hancock Mutual Life Insurance Co.; the Equitable Life Assurance Society of the United States; Metropolitan Life Insurance Co.; Pan-American Life Insurance Co.; Union Mutual Life Insurance Co.; Pilot Life Insurance Co.; Continental Casualty Co.; General American Life Insurance Co.; Occidental Life Insurance Co. of California.

Collectively, these 15 carriers pay part B (supplementary medical insurance) benefits for approximately 8 million beneficiaries, including all the railroad retirement beneficiaries who are served by the Travelers Insurance Co. The first five companies mentioned also serve as fiscal intermediaries for hospitals, home health agencies, and extended care facilities under part A (hospital insurance benefits).

We appreciate this opportunity to give you a brief report of our activities to date, to offer comments with respect to H.R. 5710, and to answer questions you may have concerning our work as carriers and fiscal intermediaries.

First of all, Mr. Chairman, we wish to state that without the great dedication, hard work, and long hours spent on the job by Secretary Gardner, Commissioner Ball, Bureau of Health Insurance Director Hess, and their many associates, the medicare program would not have

gotten on the road nor would it have reached the level of success it has achieved today.

Our relationships with these men and women have been congenial and productive. We also must take note of the good spirit shown by physicians, hospitals, and other providers of service in their continuing cooperation with us from the very outset.

During the first half of 1966 we spent a great deal of time in consultation with officials of the Social Security Administration who were establishing the various administrative functions and procedures to be used in carrying out the role assigned to us. We hoped that we could speed the development of the medicare program by adapting our regular administrative practices based on long experience in serving the millions of people insured for comprehensive medical expense benefits.

Specifically, we had anticipated that the carriers would be assigned certain beneficiaries for whom they would keep benefit records, determine deductible amounts and pay benefits. This is our regular claim-handling procedure.

The Social Security Administration decided to program all records into its central computer system in Baltimore. Thus, it became necessary for the insurance companies to tie in with the computer in order to "ask" it for day-to-day information about each beneficiary before payment of a claim could be made.

As you will appreciate, new systems seldom perform to perfection the first time around. This system was no exception. We are working with the Social Security Administration to eliminate the bugs and hopefully to make the medicare system as efficient as our own.

Some of you or your colleagues may have received complaints about delays in the payment of medicare benefits. It is true that there have been a number of delays. However, it should be appreciated that the size and scope of medicare made it virtually impossible to predict in advance with any high degree of accuracy either the ultimate number of bills to be processed by any given carrier or how fast the bills would come in.

These unexpected claim delays are being coped with by the carriers through extensive use of overtime and of personnel from their own business. Delays should be minimal in the future.

Let me emphasize, however, that these payment delays have not affected the beneficiaries' ability to secure the medical services which the program is intended to cover.

The Social Security Administration has made a yeoman effort to inform the public about the medicare program. The carriers have conducted information programs of their own beamed toward providers of service, physicians, physicians' assistants, and other groups.

Despite all this work, an even stronger communications effort is needed and will be made. In particular, the insurance company carriers will intensify their efforts to guide the medical assistants of physicians in aiding patients with the proper filing of their claims. The errors made by the beneficiaries in filing claims have been a major factor in delaying claims processing.

Our experience indicates that most physicians have been exemplary in their treatment of medicare beneficiaries in terms of both medical attention and fees. Our claim processing systems are designed to

screen out borderline cases as well as the unusual cases. We make many inquiries and investigations in order to resolve missing or questionable aspects of a claim.

DETERMINATION OF REASONABLE CHARGES

In connection with physicians' charges I turn now to a subject which is of deep concern to the insurance company carriers and which involves a recently proposed regulation (attached) establishing criteria for carrier determination of reasonable charges.

Section 1842(b) (3) of Public Law 89-97 states that—

In determining the reasonable charge for services * * * there shall be taken into consideration the customary charges for similar services generally made by the physician * * *, as well as the prevailing charges in the locality for similar services."

If this sounds like a simple task, let me assure you that it isn't. Seldom has a task requiring so much judgment and tact been described by so few words.

Why is this so? Because relatively few physicians have a customary charge for other than their more common services, such as initial office visits, subsequent office visits, and so forth, and even these customary charges do not necessarily conform to any published fee schedule.

Furthermore, many physicians do not publicize their established customary charges and hence the carrier must learn of them by observation or discreet inquiry.

Finally, physicians do change their customary charges from time to time. The determination of prevailing charges in a given locality can require even more skill.

So far, the carriers have been free to exercise their best judgment in performing this task. The inclusion in the proposed regulation of guidelines in terms of certain mathematical concepts and formulas raises the question as to what might happen at some future date if these criteria were to be interpreted as rigid rules rather than flexible guidelines.

We are particularly concerned that the proposed regulation contains only one example of "an acceptable method" of determining prevailing charges and that this method is a complex mathematical formula which will often produce results that are at odds with the best judgment of the carrier.

At the time Public Law 89-97 was enacted, it was our understanding that the Congress desired the use of voluntary health insurance organizations in order to utilize their experienced judgment in settling medicare claims. If our understanding is correct, it would be well to have the committee restate that the carriers are expected to have a fair degree of latitude in settling claims and to be allowed to determine reasonable charges in accordance with their best judgment.

RECOMMENDATIONS ON PROPOSED AMENDMENTS IN H.R. 5710

Now we would like to offer several specific recommendations concerning the proposed amendments in H.R. 5710.

Section 130 "Outpatient Hospital and Diagnostic Specialty Benefits for the Aged and Disabled." We endorse the principle behind the change in outpatient benefits proposed in this section because it simplifies a complex benefit provision and billing procedure. This change would assist all parties concerned.

To give you an idea of what is presently involved, the cost of a typical outpatient visit must be split three ways, each calling for special billings. Then the social security office in Baltimore must be queried, and if all is well, the fiscal intermediary must pay the hospital in two parts, one chargeable to the hospital insurance trust fund, and the other to the supplementary medical insurance trust fund.

The part B carrier pays yet a third benefit. The beneficiary then receives two letters, one from the part A fiscal intermediary, and the other from the part B carrier, advising him of what has happened.

Indeed, a number of hospitals have declined to bill medicare for outpatient benefits rather than incur the relatively high cost of billing. Whether section 130 is adopted as now written or in some modified form, the fiscal intermediaries and carriers will need sufficient lead time to reprogram their computers to accommodate the change in benefits.

We, therefore, request that this section not be made effective earlier than January 1, 1968.

Section 131. Elimination of requirement of physician certification in the case of inpatient hospital services at time individual becomes an inpatient. We support this section because it eliminates a duplicate requirement that is causing unnecessary work. Briefly, the act currently requires that a physician certify every admission to a hospital. The hospitals themselves have always had an equivalent requirement.

In other words, there is now a double requirement. This section is a step in the right direction. It eliminates the initial certification requirement for general hospitals. We recommend that it go further and apply to all providers of service.

Section 153. Underpayments. We urge the adoption of this section, which permits carriers to process claims promptly where a beneficiary has died. At present we run the risk of long delays in payment of benefits under these circumstances.

Section 161. Services of interns and residents as inpatient hospital services. We support this section because it provides a solution to an apparent ambiguity between parts A and B.

In brief, part A includes the services of interns and residents under approved training programs as a "covered hospital cost." If they do not work under an approved training program, their professional services are covered under part B. We believe section 161 is an answer to the problem, and will allow the processing of some claims which have not been filed because of the present situation.

Section 162. Payment for the purchase of durable medical equipment. We endorse the objective of this section, but urge that it go further. The section deals with the acquisition of durable medical equipment, as, for example, a wheelchair, where the patient will need it for so long a time that it is cheaper to buy the equipment than to rent it. This is a familiar situation to private insurers.

Many of our group medical expense insurance policies provide benefits for the rental of durable medical equipment, and even though

our policies are silent on the subject, we pay for outright purchase of the equipment when that seems more economical.

Under medicare the carriers do not have this discretionary power, and we believe they should. Section 162 provides that a beneficiary can take title to equipment under specified lease-purchase arrangements without forfeiting his medicare benefits.

However, lease-purchase arrangements are not always available, and we therefore recommend that the section be amended to allow the carrier to use its judgment in reimbursing a beneficiary who has purchased durable medical equipment he needs, so long as the cost is reasonable, compared with the probable long-term rental charges.

SUGGESTED RELIEF FOR HARDSHIP UNDER RECEIPTED BILL REQUIREMENT

There is one improvement we had hoped to see in H.R. 5710 which is not there, namely, relief from the receipted bill requirement. As the act now stands, section 1842(b) (3) (B) (ii) requires that a payment which is based on charges, "will be made on the basis of a receipted bill, or on the basis of an assignment under the terms of which the reasonable charge is the full charge for the service."

The percentage of physicians accepting assignments under medicare varies considerably from one location to another. Overall, however, it appears to be about 50 percent. This means that many beneficiaries may be forced to borrow money in order to secure the necessary receipted bill.

We would suggest correcting this situation by providing for a third method of payment, namely, a payment made jointly to the beneficiary and the physician. The payment of the benefit would be drawn jointly to the physician and the beneficiary and would be sent to the beneficiary who would enter his endorsement and then forward it on to the physician in partial settlement of his bill. This third method would be used wherever the beneficiary submitted an unreceipted and unassigned bill. The carrier's determination of the reasonable charge would not be binding on the physician or the supplier.

We urge that H.R. 5710 be amended to adopt this joint-payee method of payment.

Finally we recommend that no additional changes be made at this time in either the payment procedures or the benefits structures such as the deductibles and the coinsurance. We make this recommendation for two important reasons.

First, it takes many months, sometimes over a year, to design or redesign the complex computers program required. Second, although our medicare systems are working, they are not working as well as they should. We want to perfect our systems in order to achieve a high degree of efficiency. This effort will be unduly delayed if there are significant changes in the program beyond those we have already recommended.

In summary, Mr. Chairman, in my testimony I have reviewed some of the major problems in the areas of administration and communications and have presented the reasons why we support certain proposed amendments. It is my hope that you and your committee will find these comments and suggestions useful. We wish to continue to contribute to the further success of the medicare program.

If we can provide additional information to assist the committee in its deliberations we stand ready to do so.

Thank you.

The CHAIRMAN. Mr. Pettengill, we thank you, sir, for coming to the committee. We appreciate Mr. White and Mr. Hanna and Mr. Hawkins accompanying you. We appreciate your analysis of the situation from the point of view of the insurance intermediaries, also your comments on provisions of the bill.

I think it would be appropriate for the material attached to your statement to appear in the record at this point.

Mr. PETTENGILL. If it is your pleasure, sir.

The CHAIRMAN. If there is no objection, it will be made a part of the record.

(The proposed regulation referred to follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Social Security Administration

[20 CFR Part 405]

HEALTH INSURANCE PROGRAM FOR THE AGED

Notice of Proposed Rule Making

Notice is hereby given, pursuant to the Administrative Procedure Act, as amended, that the regulations set forth below in tentative form are proposed by the Commissioner of Social Security, with the approval of the Secretary of Health, Education, and Welfare. The proposed regulations (§ 405.501 et seq.) relate to the criteria for determination of reasonable charges for services of physicians and other persons furnishing medical and other health services covered under the supplementary medical insurance program and the principles for determining whether reimbursement for the services of interns, residents, and supervising physicians rendered in connection with graduate medical education programs will be made under Part A or Part B of title XVIII of the Social Security Act.

Prior to the final adoption of the proposed regulations, consideration will be given to any data, views, or arguments pertaining thereto which are submitted in writing, in duplicate, to the Commissioner of Social Security, Department of Health, Education, and Welfare Building, Fourth and Independence Avenue SW., Washington, D.C. 20201, within a period of 30 days from the date of publication of this notice in the FEDERAL REGISTER.

The proposed Federal Health Insurance for the Aged regulations are to be issued under the authority contained in sections 1102, 1814(b), 1833(a), 1842(b), and 1871, 49 Stat. 647, as amended, 79 Stat. 296, 79 Stat. 302, 79 Stat. 310, 79 Stat. 331; 42 U.S.C. 1302, 1395 et seq.

[SEAL]

ROBERT M. BALL,
Commissioner of Social Security.

Approved: January 28, 1967.

WILBUR J. COHEN,
*Acting Secretary of Health,
Education, and Welfare.*

SUBPART E—CRITERIA FOR DETERMINATION OF REASONABLE CHARGES; REIMBURSEMENT FOR SERVICES OF HOSPITAL INTERNS, RESIDENTS, AND SUPERVISING PHYSICIANS

§ 405.501 *Determination of reasonable charges.*

Payment for medical and other health services (see § 405.251) furnished by physicians or other persons (except for services furnished by group practice prepayment plans electing cost reimbursement and certain services furnished by, or under arrangements made by, a provider of services) is made on the basis of the "reasonable charge" for such service which is determined by the carriers

selected by the Secretary to assist in the administration of the supplementary medical insurance program.

§ 405.502 *Criteria for determining reasonable charges.*

(a) *Criteria.* The two criteria set out in the law which are considered in determining reasonable charges are:

(1) The customary charges for similar services generally made by the physician or other person furnishing such services; and

(2) The prevailing charges in the locality for similar services.

(b) *Comparable services limitation.* The law also specifies that the reasonable charge cannot be higher than the charge applicable for a comparable service under comparable circumstances to the carriers' own policyholders and subscribers.

(c) *Application of criteria.* In applying these criteria, the carriers are to exercise judgment based on factual data on the charges made by physicians to patients generally and by other persons to the public in general and on special factors that may exist in individual cases so that determinations of reasonable charges are realistic and equitable.

(d) *Responsibility of administration and carriers.* Determinations by carriers of reasonable charge are not reviewed on a case-by-case basis by the Social Security Administration, although the general procedures and performance of functions by carriers are evaluated. In making determinations, carriers apply the provisions of the law under broad principles issued by the Social Security Administration. These principles are intended to assure overall consistency among carriers in their determinations of reasonable charge. The principles in §§ 405.503-405.507 establish the criteria for making such determinations in accordance with the statutory provisions.

§ 405.503 *Determining customary charges.*

(a) *Uniform amount.* The term "customary charges" will refer to the uniform amount which the individual physician or other person charges in the majority of cases for a specific medical procedure or service. In determining such uniform amount, token charges for charity patients and substandard charges for welfare and other low income patients are to be excluded. The reasonable charge cannot, except as provided in § 405.506, be higher than the individual physician's or other person's customary charge. The customary charge for different physicians or other persons may, of course, vary. The law does not contemplate the establishment of a general fee schedule applicable to all physicians or other persons furnishing medical and other services but calls for individual determinations which take into account the facts as to existing practice with respect to charges of the particular physician or other person as well as others in the locality. However, payment for a covered service would be based on the actual charge for the service when, in a given instance, that charge is less than the amount which the carrier would otherwise have found to be within the limits of acceptable charges for the particular service. Moreover, the income of the individual beneficiary is not to be taken into account by the carrier in determining the amount which is considered to be a reasonable charge for a service rendered to him. There is no provision in the law for a carrier to evaluate the reasonableness of charges in light of an individual beneficiary's economic status.

(b) *Variation of charges.* If the individual physician or other person varies his charges for a specific medical procedure or service, so that no one amount is charged in the majority of cases, it will be necessary for the carrier to exercise judgment in the establishment of a "customary charge" for such physician or other person. In making this judgment, an important guide, to be utilized when a sufficient volume of data on the physician's or other person's charges is available, would be the median or mid-point of his charges, excluding token and substandard charges as well as exceptional clustering of charges in the vicinity of the median amount might indicate that a point of such clustering should be taken as the physician's or other person's "customary" charge. Use of relative value scales will help in arriving at a decision in such instances.

(c) *Use of relative value scales.* If, for a particular medical procedure or service, the carrier is unable to determine the customary charge on the basis of reliable statistical data (for example, because the carrier does not yet have sufficient data or because the performance of the particular medical procedure or service by the physician or other person is infrequent), the carrier may use

appropriate relative value scales to determine the customary charge for such procedure or service in relation to customary charges of the same physician or person for other medical procedures and services.

(d) *Revision of customary charge.* A physician's or other person's customary charge is not necessarily a static amount. Where a physician or other person alters his charges, a revised pattern of charges for his services may develop. Where on the basis of adequate evidence, the carrier finds that the physician or other person furnishing services has changed his charge to the public in general for a service, the revised charge may be recognized as the customary charge in making determinations of reasonable charges for such service when rendered thereafter to supplementary insurance beneficiaries. If the new customary charge is not above the prevailing level, it may be deemed to be reasonable by the carrier, subject to the provisions of § 405.508.

§ 405.504. *Determining prevailing charges.*

(a) *Ranges of charges.* The term "prevailing charges" refers to those charges which fall within the range of charges most frequently and most widely used in a locality for a particular medical procedure or services. The top of this range establishes, except as provided in § 405.506, an overall limitation on the charges which a carrier will accept as reasonable for a given medical procedure or service. Prevailing charges are derived from the overall pattern existing within a locality. For example, in a given locality the carrier may find that the charges most frequently and widely used by physicians for a particular medical procedure range from \$150 to \$175. If in another locality the carrier finds that the prevailing charges are different for the same procedure, then a different range of charges would be applied in making reasonable charge determinations for that locality. An acceptable method for the carrier to objectively determine that the point at which such limitation is established would be the use of the mean (arithmetic average) of the customary charges of physicians or other persons in the locality for a given medical procedure or service, plus one standard deviation above the mean, rounded to the next highest dollar. However, the carrier will adopt an appropriate limit for each procedure or service with judgment being exercised to assure that with respect to each particular array of data the result reached is reasonable. If, for example, there is a point just above the standard deviation which represents the amount charged by a substantial number of physicians in the locality, the limitation might, in such a situation, be established so as to include this point. On the other hand, the "trailing off" of an appreciable number of charges above the mean plus one standard deviation would not justify an upward adjustment. The "standard deviation" is a basic statistical measure widely used in dealing with variations from a central tendency or norm. Its advantage over the approach that the "prevailing charge" is to include a fixed percentage of all charges lies in the fact that the standard deviation is flexible rather than rigid. It takes into account and is responsive to differences in the spread that exists in the underlying data.

(b) *Variation in range of prevailing charges.* The range of prevailing charges in a locality may be different for physicians or other persons who engage in a specialty practice or service than for others. Existing differentials in the level of charges between different kinds of practice or service could, in some localities, lead to the development of more than one range of prevailing charges for application by the carrier in its determinations of reasonable charges. Carrier decisions in this respect should be responsive to the existing patterns of charges by physicians and other persons who render covered services, and should establish differentials in the levels of charges between different kinds of practice or service only where in accord with such patterns.

(c) *Reevaluation and adjustment of prevailing charges.* Determinations of prevailing charges by the carrier are to be reevaluated and adjusted from time to time on the basis of factual information about the charges made by physicians and other persons to the public in general. This information should be obtained from all possible sources including a carrier's experience with its own programs as well with the supplementary medical insurance program.

§ 405.505 *Determination of "locality."*

"Locality" is the geographical area to be determined by the carrier and used for deriving the prevailing charge for services. Usually, a locality will be a political or economic subdivision of a State. It should include a cross section of the population with respect to economic and other characteristics. Where people

tend to gravitate toward certain population centers to obtain medical care or service, localities may be recognized on a basis constituting medical service areas (interstate or otherwise), comparable in concept to "trade areas." Localities may differ in population density, economic level, and other major factors affecting charges for services. Carriers therefore shall delineate "localities" on the basis of their knowledge of local conditions. However, distinctions between localities are not to be so finely made that a "locality" includes only a very limited geographic area whose population has distinctly similar income characteristics (e.g., a very rich or very poor neighborhood within a city).

§ 405.506 Charges higher than customary or prevailing charges.

A charge which exceeds either the customary charge of the physician or other person who rendered the medical or other health service, or the prevailing charge in the locality, or both, may be found to be reasonable but only where there are unusual circumstances, or medical complications requiring additional time, effort or expense which support an additional charge, and only if it is acceptable medical or medical service practice to make an extra charge in such cases. On the other hand, the mere fact that the physician's or other person's customary charge is higher than prevailing would not justify a determination of reasonable charge higher than the prevailing charge.

§ 405.507 Illustrations of the application of the criteria for determining reasonable charges.

The following examples illustrate how the general criteria on customary charges and prevailing charges might be applied in determining reasonable charges under the supplementary medical insurance program. Basically, these examples demonstrate that, except where the actual charge is less, reasonable charges will reflect current customary charges of the particular physician or other person within the ranges of the current prevailing charges in the locality for that type and level of service:

"The prevailing charge for a specific medical procedure ranges from \$80 to \$100 in a certain locality.

"Doctor A's bill is for \$75 although he customarily charges \$80 for the procedure.

"Doctor B's bill is his customary charge of \$85.

"Doctor C's bill is his customary charge of \$125.

"Doctor D's bill is for \$100, although he customarily charges \$80, and there are no special circumstances in the case.

"The reasonable charge for Doctor A would be limited to \$75 since under the law the reasonable charge cannot exceed the actual charge, even if it is lower than his customary charge and below the prevailing charges for the locality.

"The reasonable charge for Doctor B would be \$85 because it is his customary charge and it falls within the range of prevailing charges for that locality.

"The reasonable charge for Doctor C could not be more than \$100, the top of the range of prevailing charges.

"The reasonable charge for Doctor D would be \$80, because that is his customary charge. Even though his actual charge of \$100 falls within the range of prevailing charges, the reasonable charge cannot exceed his customary charge in the absence of special circumstances."

§ 405.508 Determination of comparable circumstances; limitation.

(a) *Application of limitation.* The carrier may not in any case make a determination of reasonable charge which would be higher than the charge upon which it would base payment to its own policyholders for a comparable service in comparable circumstances. The charge upon which it would base payment, however, does not necessarily mean the amount the carrier would be obligated to pay. Under certain circumstances, some carriers pay amounts on behalf of individuals who are their policyholders, which are below the customary charges of physicians or other persons to other individuals. Payment under the supplementary medical insurance program would not be limited to these lower amounts.

(b) *When comparability exists.* "Comparable circumstances," as used in the Act and this subpart, refers to the circumstances under which services are rendered to individuals and the nature of the carrier's health insurance programs and the method it uses to determine the amounts of payments under these programs. Generally, comparability would exist where:

(1) The carrier bases payment under its program on the usual and customary charges of physicians or other persons and on current prevailing charges in a locality, and

(2) The determination does not preclude recognition of factors such as specialty status and unusual circumstances which affect the amount charged for a service.

(c) *Responsibility for determining comparability.* Responsibility for determining whether or not a carrier's program has comparability will in the first instance fall upon the carrier in reporting pertinent information about its programs to the Social Security Administration. When the pertinent information has been reported, the Social Security Administration will advise the carrier whether any of its programs have comparability.

§ 405.520 Reimbursement for services of interns, residents and supervising physicians; general.

(a) Under the health insurance program, almost all the aged have protection against hospital expenses, and the great majority also have protection against medical expenses. This health insurance coverage is intended to provide a substantial measure of freedom to beneficiaries in selecting hospitals and physicians of their choice. Whatever the choice, beneficiaries, as insured patients, are to be accorded the same status as other insured and paying patients in regard to the hospital and medical care they are provided.

(b) Many beneficiaries will choose to receive the care they need from hospitals with approved graduate medical education programs and from other institutions where services of interns and residents are provided. Many will receive care in these hospitals as patients of physicians who, in turn, will involve interns and residents in the care of their patients. The basis for reimbursement for such services by interns and residents is different from that applicable to such physicians' services.

§ 405.521 Services of attending physicians supervising interns and residents.

(a) Attending physicians' services rendered to beneficiaries in a teaching setting are covered under the supplementary medical insurance program and the payment for such services is on the basis of reasonable charges (see pars. (b) and (c) of this section). The costs to a hospital for teaching services furnished by a physician in connection with an approved graduate medical education program are allowable in accordance with the principle of reimbursement for provider costs (see par. (d)).

(b) Payment on the basis of reasonable charges is applicable to the professional services rendered to a beneficiary by his attending physician where the attending physician provides personal and identifiable direction to interns or residents who are participating in the care of his patient. In the case of major surgical procedures and other complex and dangerous procedures or situations, such personal and identifiable direction must include supervision in person by the attending physician. A charge should be recognized under Part B for the services of an attending physician who involves residents and interns in the care of his patient only if his services to the patient are of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients. The carrying out by the physician of these responsibilities would be demonstrated by such actions as: Reviewing the patient's history and physical examination and personally examining the patient with a reasonable period after admission; confirming or revising diagnosis; determining the course of treatment to be followed; assuring that any supervision needed by the interns and residents was furnished; and by making frequent reviews of the patient's progress.

(c) Changes for such services of the attending physician may be billed either directly by him or by the hospital under arrangements between the physician and the hospital. In either case, the amount payable under the program for such services may be determined in accordance with the same criteria for the determination of reasonable charges as are applicable to the services which the physician renders to his other patients (see §§ 405.501-405.508 of this Subpart E).

(d) It is recognized that there will necessarily be situations where a patient will receive medical services in the teaching setting for which payment on the basis of reasonable charges will not be applicable. For example, there will be instances where it will neither be necessary from the standpoint of the medical needs of the patient nor appropriate from the standpoint of the continuing

development of the residents' competence for there to be an attending physician who carries out the responsibilities referred to in paragraph (b) of this section. Whether or not a physician makes a charge recognized under the supplementary medical insurance program for services to patients which involve the participation of residents or interns, the hospital can receive reimbursement on a cost basis for an appropriate share of the compensation it pays its residents and interns. If the teaching program is an approved educational activity of the hospital, reimbursement will also be available on a cost basis to the hospital for an appropriate share of the compensation it pays to physicians for teaching services (as opposed to professional services which contribute to the diagnosis or treatment of the patient) and for other costs of educational programs conducted by the hospital. These costs are allowable in accordance with the principles of reimbursement for provider costs (see § 405.421 of Subpart D).

(e) Nothing in the foregoing restricts the disposition of payments for services received either from the health insurance program or from beneficiaries, in accordance with agreements between hospital and physicians.

§ 405.522 Interns' and residents' services in approved teaching programs.

(a) Title XVIII of the Act gives recognition to hospital teaching programs which are duly approved in their respective fields by the Council on Medical Education of the American Medical Association, the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, or the Council on Dental Education of the American Dental Association.

(b) Services of interns and residents in such approved programs are explicitly excluded from the definition of "physicians' services" (see Subpart R) and are covered as hospital services. This exclusion applies whether or not the intern or resident may be authorized to practice as a physician under the laws of the State in which he performs his services. In accordance with the basis for payment under the health insurance program for services provided by participating hospitals, the cost of the services of interns and residents is reimbursable to the hospital, specifically as a component of allowable costs defined by the principles of reimbursement for provider costs set forth in Subpart D of Part 405. Under the principles discussed in Subpart D of this Part 405, an appropriate share of the provider's total allowable costs is reimbursable under the health insurance program. (For purposes of including services of interns and residents as an element of allowable cost in accordance with these principles, recording and reporting by the hospital of the specific services rendered to individual beneficiaries is not necessary.)

(c) Conversely, services of interns and residents are not reimbursable under the health insurance program on the basis which applies to physicians' services; i.e., reasonable charges (see §§ 405.501–405.508 of this Subpart E). This distinction with respect to the basis for the health insurance program reimbursement applies to services of interns and residents whether covered by the hospital insurance program or the supplementary medical insurance program. The cost of outpatient diagnostic services (see § 405.145) covered under the hospital insurance program (see Subpart A of Part 405) and other outpatient services (see § 405.231) covered under the supplementary medical insurance program (see Subpart B of Part 405) which are provided by a hospital, including intern and resident services where involved, is reimbursed to the hospital under the health insurance program to the extent of 80 percent of the cost of services rendered to the beneficiaries after recognition of the deductible amount (see § 405.142 and § 405.240(d)). The beneficiary will incur the expense of the deductible and coinsurance amounts as determined on the basis of the hospital's charges to the beneficiary. Hospital charges may include a charge for the services of interns or residents as a specific item, or these services may be included in the general charges to the beneficiary made by the hospital for the covered services it provides.

§ 405.523 Interns' and residents' services not in approved teaching programs.

(a) The services of a hospital resident or intern who is not under an approved teaching program in the hospital are reimbursable to the hospital on a cost basis under the supplementary medical insurance program. For purposes of this section, such services shall be deemed to include services of a physician employed by the hospital who is authorized to practice only in a hospital setting. Even where such services are rendered to inpatients, the cost of the services is not an allowable cost under the hospital insurance program but is allowable under the supplementary medical insurance program.

(b) In this connection reimbursement under the health insurance program for services discussed in paragraph (a) of this section will be to the hospital in an amount of 80 percent of the cost of services rendered to the beneficiaries after recognition of the deductible. The beneficiary will incur the expense of the deductible and coinsurance amounts as determined on the basis of the hospital's charges to the beneficiary for its services that are covered under the supplementary medical insurance program.

§ 405.524 *Interns' and residents' services outside the hospital.*

(a) Under the hospital insurance program, the allowable costs on which reimbursement to a participating extended care facility for covered services is based may include the cost of services of an intern or resident who is under an approved teaching program in a hospital with which the facility has a transfer agreement (see § 405.1133) which provides, in part, for the transfer of patients and the interchange of medical records. Likewise, a participating home health agency may be reimbursed under the hospital insurance program for the cost of the services of an intern or resident who is under an approved teaching program of a hospital with which the home health agency is affiliated or under common control, where these services are furnished as part of the posthospital home health visits for a medicare beneficiary.

(b) Medical services of a resident or intern by a hospital which are furnished by a provider of services are reimbursed under the supplementary medical insurance program on an 80 percent of allowable cost basis if reimbursement is not provided under the hospital insurance program.

§ 405.525 *Basis of reimbursement under the health insurance program for services of interns and residents.*

Status of patient	Status of intern or resident ¹	Reimbursement provided under ²	Basis of payment ³
Hospital inpatient.....	Under approved program.....	Part A.....	Cost.
	Other.....	Part B.....	80 percent of cost.
Receiving outpatient hospital diagnostic services.	Under approved program.....	Part A.....	Do.
	Other.....	Part B.....	Do.
Receiving therapeutic outpatient hospital services.	Under approved program.....	do.....	Do.
	Other.....	do.....	Do.
Extended care facility inpatient.	Under approved program of a hospital with which facility has a transfer agreement.	Part A.....	Cost.
	Other.....	Part B.....	80 percent of cost.
Home health plan patient.	Posthospital services furnished under approved programs of hospital with which the Home Health Agency is affiliated or under common control.	Part A.....	Cost.
	Other.....	Part B.....	80 percent of cost.

¹ An "approved program" means approval by the Council on Medical Education of the AMA, by the Committee on Hospitals of the Bureau of Professional Education of the AOA, or by the Council of Dental Education of the ADA. "Other" interns and residents include, in addition to interns and residents-in-training, a physician employed by a hospital and acting in the capacity of an intern or resident.

² "Part A" refers to the hospital insurance program and "Part B" refers to the supplementary medical insurance program.

³ The term "cost" refers to reimbursement on a cost basis in accordance with the principles in Subpart D of Part 405.

[F.R. Doc. 67-1492; Filed, Feb. 7, 1967; 8:47 a.m.]

The CHAIRMAN. Mr. Pettengill, what is the position of your group on the proposed part C?

Mr. PETTENGILL. The proposed part C, sir, consists of actually two pieces. One is the gathering together of the various outpatient benefits, that is, benefits for hospital outpatient charges, into a single outpatient benefit. Even though it is called part C, it would in actuality be a covered expense under part B of the program available only to those who subscribe for part B and subject to the \$50 calendar deductible and the 20 percent coinsurance.

This is one way of arriving at a single hospital outpatient benefit. It seems reasonable to us and, as I mentioned to you in my text, we feel it is highly desirable to simplify the outpatient benefit.

I might mention for your information that in my own company we find that the hospitals are having to make out these various outpatient bills and send them to us and yet in less than one-third of the cases are we able to pay any actual dollar benefits back to the hospitals.

In other words, this is a tremendous amount of paperwork for very little return.

Now, the other piece of part C is a reorientation of the professional services of physicians with respect to diagnostic X-rays and diagnostic laboratory work. Here the suggestion is that if this work is done while other than an inpatient in the hospital, it should be under part B. Even though this is called part C, nevertheless, effectively it is under part B and is subject to the part B deductible and coinsurance. If the work is done while an inpatient in the hospital, then payment shall be under part A at the rate of 100 percent and without any deductible.

We do not deny that this would be a simplification over the present arrangement, but we would point out that certainly you should consult with the doctors and the hospitals as to whether this is an appropriate mechanism, and certainly it does create an advantage to having work done in the hospital rather than out of the hospital because 100-percent reimbursement always sounds better to the public than 80 percent.

The CHAIRMAN. Mr. Pettengill, in determining reasonable charges for the medicare beneficiaries are your procedures more complex and administrative costs greater than they are for your regular clients under age 65?

Mr. PETTENGILL. Yes, sir.

The CHAIRMAN. Will you give us some information on the reasons why?

Mr. PETTENGILL. It is our understanding of the Social Security Administration's regulations as thus far promulgated that we need to be very carefully satisfied in connection with each claim that we have the doctor's customary charge for the particular procedure or procedures that he has rendered the beneficiary.

Now, our interpretation of this requirement is that literally we must have the same sort of assurance of his customary charges as a fiscal intermediary is required to have under the hospital program: re a physician's certification of admission. We feel we should, and in our regular business we do exercise a certain degree of judgment. If the nature of the illness which is reported to us and the nature of the services which were rendered are compatible, say the physician made two or three office calls plus perhaps a little office diagnostic work for a minor illness for which he made just one charge which seems reasonable for this physician, we accept that single charge under our regular business as complying and being his customary charge.

We do not require that we have the actual dates of each of these treatments, the actual individual procedures performed at each of these treatments, and that the customary charge for each of these procedures be precisely thus and so.

Consequently, if we are to carry out what we understand to be the requirements it involves a tremendous additional amount of work, and time, and effort which we question to be proper. We feel that our judgment should be permitted, and in many cases in these recent weeks where we have had a heavy claim load we have relied on our judgment.

The CHAIRMAN. What is your thinking, Mr. Pettengill, as to the overall cost of the program? Would it be greater if we endeavored to assist you in bringing down these administrative costs which are higher for this group than for your regular group under 65?

Mr. PETTENGILL. Mr. Chairman, as you can appreciate, the program is only 8 months old and even under our regular business we are unable to tell you a brand new policyholder whose program is only 8 months old exactly how his program is going either benefitwise or expensewise.

The CHAIRMAN. I understand the difficulty of your answering absolutely the question I raise, but in your opinion, could we expect an increase in the overall cost of the program if we tried to do what you recommend and suggest to reduce the administrative costs?

Mr. PETTENGILL. You are referring to the suggestions we made?

The CHAIRMAN. If you don't follow the rigidity which is in present regulations, which you point out does raise your administration costs, then would we be, on the other hand, raising the overall costs of the program?

Mr. PETTENGILL. This is a question of do you incur more benefits in claim dollars and therefore in the aggregate you suffer more expenses than you save in claim handling?

In other words, pennywise and pound foolish.

The CHAIRMAN. You raised the question much better than I did.

Mr. PETTENGILL. I believe, sir, that within reason it is possible to exercise a high degree of judgment in determining a physician's customary charge without increasing the actual claim cost, so that we believe we could reduce what will probably be our claim settlement cost under this program by a significant amount without increasing the benefit costs.

The CHAIRMAN. I wanted your judgment on that point.

Is your backlog of claims now being reduced compared to, say, what the situation was in August, September, and October?

Mr. PETTENGILL. Very definitely, sir.

The CHAIRMAN. How much improvement would you assess under the situation now as compared to then?

Mr. PETTENGILL. I do not have a figure for each of the companies, sir, but I know that in the case of my own company we are now down to a figure which is, I would say, going to be about routine when you consider the complexity of this operation. We are down to a figure which is a little less than 2 weeks' processing time, of which approximately half is involved in querrying Baltimore and getting a reply back.

The CHAIRMAN. That is with respect to both the hospital payment as well as the physician payment under B?

Mr. PETTENGILL. Yes. There has never been in my judgment, at least as far as the carriers I am speaking for, any great delay on the part A.

The CHAIRMAN. It has been with respect to part B.

Mr. PETTENGILL. Part B was the place where we did run into certain delays and as far as I know these have been very well resolved in recent weeks.

The CHAIRMAN. So it is now being made within approximately 2 weeks?

Mr. PETTENGILL. As far as my company, and I think other companies are close to mine, sir.

The CHAIRMAN. How does this time correspond with the time that it takes you to make a payment under a policy that you may have issued to someone under 65?

Mr. PETTENGILL. Talking about a clean case, and I think your committee realizes that when you have a complicated case which requires referral to medical referees—

The CHAIRMAN. I am talking about the average kind of case that you would have where the bill comes in under one of your insurance policies.

Mr. PETTENGILL. Speaking now to the group insurance policies, which are the ones that are most closely analogous to this program as contrasted with an individual policy—

The CHAIRMAN. That is right.

Mr. PETTENGILL. Speaking with respect to group insurance policies, I would say that we would expect to pay somewhere within the neighborhood of 4 to 5 working days under our regular business and under Medicare we are paying somewhere within the neighborhood of 8 to 10 working days, and the reason for this difference is primarily this requirement that we must query Baltimore not only for eligibility, but also for the deductible status and in the case of certain mental conditions as to the actual amount of benefits available, and it takes time, I think you can appreciate, to query Baltimore and to receive replies back.

In fairness to the Social Security Administration, they are aware of this and they are working to try to shorten this time down, but, nevertheless, it will always take certain additional amounts of time.

The CHAIRMAN. Do you ordinarily make a payment with respect to an individual's policy, not a group policy, but an individual's policy, within this 2-week period, or would it be longer than 2 weeks?

Mr. PETTENGILL. I am sure that the individual policies vary materially from one carrier to another, but in many of those situations if the records are centralized in the insurance company then it probably might take as long as 8 to 10 days to pay under an individual policy.

The CHAIRMAN. But you think this program that we are hearing about here is more comparable to your group term policy?

Mr. PETTENGILL. Correct.

The CHAIRMAN. All right. Evidently you have some question about the establishment of what is the reasonable charge itself. With respect to the regulations on reasonable charges, generally are they reasonable and appropriate or not?

Mr. PETTENGILL. I do not question the fact that we should consider mathematical formulas, but I respectfully submit that the nature of a physician's charge is not precisely measurable by mathematical

formulas and therefore, it would be wrong to substitute mathematical formulas for good judgment.

Our concern is that because these mathematical formulas have been referred to in the regulations there might some day be an interpretation that we were to follow these formulas very closely, whereas in actual practice our judgment might say we need to deviate markedly from the formula.

The CHAIRMAN. Mr. Pettengill, you bring to our attention a third method of making payment under part B. You describe it I believe on page 9 of your testimony.

How would this work? Give me a little bit more detail than you have in your statement as to how you envision it would work?

Mr. PETTENGILL. I think you can appreciate, sir, that in spite of all of the work of the Social Security Administration and the carriers, the carriers are still receiving large numbers of claims where the beneficiary has not paid the bill, nor has the physician accepted an assignment.

In other words, we are simply receiving an unreceipted, unassigned bill. One reason is that it is the standard practice of most insurance companies in settling their own claims. We do not require a receipted bill. We have been able to work for many years without it, and of course the ideal solution would be to allow the acceptance of an unreceipted bill under this program.

We can appreciate, however, that this presents certain difficulties. We therefore suggested the insertion of this third method.

Now, under the third method whenever we receive this unreceipted and unassigned bill we would proceed to determine that the charges were reasonable just as we would for any other claim and we would contact Baltimore with respect to the eligibility, deductible, and so on, and then having reached a decision that benefits were payable and the amount of benefits payable—in other words, all the processing is exactly the same as for a receipted bill—we would then, instead of drawing the check directly and solely to the beneficiary, draw the check payable jointly to the beneficiary and the physician or the supplier.

We would mail the check to the beneficiary with a little notice that because this was an unreceipted, unassigned bill, the check has been made out jointly to him and his physician, that he should endorse the check and forward it to the physician as part payment of his bill, and this he would do.

The physician would then be in the position of cashing the check and of billing the beneficiary for the deductible and coinsurance portion of the claim.

We believe that this would shorten considerably the average payment time because it would not be necessary for us to go back as we are doing now to the beneficiary and saying, "We are very sorry, but we cannot process this bill because it is unreceipted."

The CHAIRMAN. You have not discussed this with the medical profession? You do not know their reaction to it?

Mr. PETTENGILL. That is correct, sir; but I know of no reason why this should be unacceptable to them because it is something which we occasionally do in our regular business where there is a comparable situation.

The CHAIRMAN. Thank you again, Mr. Pettengill.

Any further questions? Mr. Byrnes.

Mr. BYRNES. Mr. Chairman, I want to express appreciation to Mr. Pettengill and his group for the help they have given us. Their testimony today was very helpful.

We heard considerable complaints, particularly from hospitals, but also from individual patients under part B, about long delays in payment of overdue claims. Are we over the hump as far as this delay is concerned?

Mr. PETTENGILL. As far as the carriers I represent, sir, we are over the hump, and may I point out that there never really was any problem with respect to part A as far as these five insurance companies were concerned.

We had a small problem with respect to part B and that we have, I believe, reasonably cleared up.

Mr. BYRNES. Where do those hospital claims originate? I have heard that there are hospitals that are 2, 3, or 4 months behind in having their claims paid. This places that individual hospital in a very difficult situation as far as their outstanding accounts receivable are concerned.

Are those just isolated cases?

Mr. PETTENGILL. You can appreciate that I speak for only five of the fiscal intermediaries, and represent less than 10 percent of the hospitals that are qualified under this program, so I would suggest, sir, that you direct your question to the other fiscal intermediaries who have a larger role.

As far as ourselves are concerned, I do not believe you will find that they have suffered any delays of any significance whatsoever.

Mr. BYRNES. And you just don't have the individual information on the other 90 percent?

Mr. PETTENGILL. You can appreciate that I have enough work to do my own job.

Mr. BYRNES. Well, you serve on advisory committees of the department, don't you?

Mr. PETTENGILL. Yes, sir.

Mr. BYRNES. And the committees have had this matter under discussion or under consideration haven't they? I thought in that connection you might be able to give us some information.

Mr. PETTENGILL. I regret to say, sir, that this particular point has not been raised at the fiscal intermediary representative group meetings.

Mr. BYRNES. Concerning the administration of the reasonable and customary charges for services under part B, you fear a rigidity may develop which differs from the normal application of this criteria to private policies.

Mr. PETTENGILL. That is right, sir.

Mr. BYRNES. Some of your policies use a very similar criteria for determining the insurer's liability?

Mr. PETTENGILL. Correct.

Mr. BYRNES. But the companies have been free to use their sound judgment and it has worked out satisfactorily?

Mr. PETTENGILL. In our judgment it has worked out very satisfactorily from both the point of view of the beneficiary whose bills

are being paid, the physician whose services are being compensated for, and the policyholders whose money is being spent.

Mr. BYRNES. But you are concerned that these other policies may be jeopardized by rigid formula for determining payment rather than the exercise of sound judgment.

Mr. PETTENGILL. That is correct, sir. In my judgment, the method and the plan would not serve the needs of the beneficiaries and the physicians anywhere near as well if we were to substitute the mathematical formula than if we were to rely on good judgment.

Mr. BYRNES. Do you know whether you are running into similar problems in this connection with part A, where payment is based on reasonable cost rather than reasonable charge?

Mr. PETTENGILL. I regret to say that we have yet to be supplied by the Social Security Administration with any of the cost data for the providers of service that we serve so that we have yet to make any of the audits required under part A, so that I am not in a position to comment, sir.

Mr. BYRNES. How do you determine that cost?

Mr. PETTENGILL. We do have a set of guidelines which has been laid down by the Social Security Administration. You can appreciate that guidelines can be administered flexibly and if this is the way they are done and we are permitted to use good judgment in making the audits of the providers I think the system will work reasonably well with due regard for the facts, which I am sure will be brought out before you by the providers themselves, that there may be certain items of cost which have not been adequately set forth in these guidelines. This is one of the things that we will know better after we have been through a set of these audits, but here again of course the same problem could arise that if these guidelines are applied with great rigidity, then there could be the same problem under part A as under part B.

Mr. BYRNES. These are postaudits?

Mr. PETTENGILL. That is correct, sir.

Mr. BYRNES. So we won't have a precise picture until there have been a number of these postaudits available for reference purposes?

Mr. PETTENGILL. Correct, sir.

Mr. BYRNES. Do you have any idea when we will have at least a sampling of postaudits on which to make some judgments?

Mr. PETTENGILL. As soon as we receive the necessary cost and statistical data from the computer in Baltimore with respect to those hospitals whose fiscal years have already closed, we will proceed with the audits and then that information will start to become available.

I do not know, but I understand that the Social Security Administration is just about ready to send us the data with respect to those of our hospitals whose fiscal years ended last fall.

Mr. BYRNES. Do you people have experience paying claims for the same kinds of services for which claims are now made under part B and also under part A?

What comments do you have on developments in the amount of the charge? I am referring to the increasing doctor's charges and increasing hospital charges. I suppose it is a fact, is it not, that these charges have been going up within the last year?

Mr. PETTENGILL. I am sure you are well aware, sir, that all medical care costs have been suffering from an escalation over the last two decades.

Mr. BYRNES. Have increases in the last year been steeper, or have they followed the trend of recent years?

Mr. PETTENGILL. With respect to physicians' charges you are asking this question?

Mr. BYRNES. Right now, yes.

Mr. PETTENGILL. This is hard for us to measure because we see of course only a small segment of the total. I would say that there possibly is a somewhat higher rate of increase, but not anything to be overly concerned with as far as physicians' charges are concerned.

Mr. BYRNES. What would your judgment be as to the hospital charges?

Mr. PETTENGILL. Here, as you are well aware, there have been many aspects of hospital costs which have risen rather sharply, primarily due to increased wages and salaries paid to their personnel, and of course this is something to which the providers of service can respond better than I, but I think we are seeing a much sharper increase in hospital costs and therefore will see a sharper increase in hospital charges.

Mr. BYRNES. When we originally discussed this in 1965, the committee was advised that there were a large number of charity cases in the group medicare would cover. It was claimed that reimbursing the hospitals on a cost basis for this group would lower the costs for these cases then being recovered through charges on the younger groups. The conclusion was that this might lead to lower hospital charges for the public generally.

Have you had enough experience with what has happened so far to make any judgment on whether this has happened?

Mr. PETTENGILL. In view of the limited number of providers which we serve, I think that this question ought better be asked of the hospital people themselves, sir.

Mr. BYRNES. Thank you very much. You have been very helpful.

The CHAIRMAN. Mr. Ullman.

Mr. ULLMAN. Mr. Pettengill, are you personally familiar with your operation in Oregon?

Mr. PETTENGILL. In a general sort of way, sir. If you have a specific question that I can't answer I will be glad to get you an answer on it.

Mr. ULLMAN. I want to talk with you privately about it; tell me which part of the program do you administer?

Mr. PETTENGILL. In Oregon, sir, we administer part B.

Mr. ULLMAN. To your knowledge is there any part of Oregon where there is a blackout of services under this program?

Mr. PETTENGILL. You mean an area where we are not paying benefits?

Mr. ULLMAN. We have a blackout in the part A section in some of the areas. I wondered whether there were any communities where you could not operate because of failure of cooperation on the part of physicians.

Mr. PETTENGILL. To the best of my knowledge, no, sir.

Mr. ULLMAN. Would you say your Oregon operation is comparable to the other States?

Mr. PETTENGILL. I happen to have six States, sir; and I would say that Oregon is quite comparable.

Mr. ULLMAN. On this matter of physicians' charges, is information available and can it be made available on a periodic basis so that we can detect trends?

Mr. PETTENGILL. Under our contracts with the Secretary, sir, we supply information to the Secretary and it is his prerogative and responsibility for making it available.

In other words, we have no authority to release information except on direction from the Secretary.

Mr. ULLMAN. This must be received from the Secretary?

Mr. PETTENGILL. Right. And I think you should appreciate, sir, that the way the procedure has been set up the fiscal intermediary and the carriers are not to duplicate the rather substantial statistical programs which the Social Security Administration has undertaken because this would mean double work and double expenses to the program, so that we are going to have to rely rather heavily on Social Security giving us back information.

Mr. ULLMAN. You said that you were hoping that the system would be set up in such a way that you could keep your own beneficiary records, but it is all being handled now by the social security system, is that right?

Mr. PETTENGILL. Correct, sir.

Mr. ULLMAN. Would you say that it is working satisfactorily or would you think it would work better the other way?

Mr. PETTENGILL. This is one of those chicken and egg deals. The point I was trying to make was that we had our experience and know-how in our own system and that being required to change over to a system which was foreign to us has created many initial tool-up problems which we have had to solve.

The only point I think that can be obviously made is that if I have a record in my claim office it obviously takes me less long to consult that record than it does to inquire of Baltimore, but whether this is a plus or a minus has to be measured in the overall pattern of the program.

Mr. ULLMAN. I assume that you are rather fully computerized now.

Mr. PETTENGILL. Well, in my particular instance, we do not have as much of a program on computers as some of the other carriers. Whether this is a plus or a minus remains to be seen. I personally have some feelings that a certain amount of individual attention is highly desirable in a program such as this. If it ever comes to the place where it is entirely computerized I think the beneficiaries will have lost and so will the physicians.

Mr. ULLMAN. You get your information from the social security system by teletype?

Mr. PETTENGILL. There are two general systems in use, sir. One is teletype and the other is the actual exchanging of computer tapes. My company happens to be tied in with the Government-teletype system and I can say that we are getting good service.

Mr. ULLMAN. By good service what do you mean? When you make a specific request at a certain hour in a day how long does it take to get a response back?

Mr. PETTENGILL. Well, when things are working at their best we are getting our replies back in 3 days. There are, of course, occasional problems such as the end of the year transition where the carryover provision came into play and right at the moment because of that I would say we probably get replies in about 5 days.

Mr. ULLMAN. That seems to me longer than it should be. Do you anticipate that even the 3-day period should be shortened?

Mr. PETTENGILL. This is something, sir, that you would have to ask the technicians in the Social Security Administration.

Mr. ULLMAN. From your point of view, do you think that a 3-day period would allow you to give the kind of service to your constituents or to the people that they should have?

Mr. PETTENGILL. Well, obviously, sir, we would prefer to have an even shorter period than 3 days. As I mentioned, in our regular business we are equipped so that we lose almost no time in checking out a beneficiary's eligibility and the status of his benefits, so that this feature of the program is bound to add more time.

The question is one of whether from the point of view of the overall program you are better off by having it centrally located here in Baltimore, and this I am afraid only time can tell.

Mr. ULLMAN. If you were handling your own beneficiary records there would be virtually no delay?

Mr. PETTENGILL. Correct, sir.

Mr. ULLMAN. As against the 3 days.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Schneebeli.

Mr. SCHNEEBELI. Mr. Pettengill, we recognize that there is a variance in the hospital charges between the big-city hospital and the small-town hospital, I think as great a differential as 30 percent in charges.

Do we find the same variation among physicians' charges as there is between hospitals depending upon locality? Is there this same variation that you tolerate or that you accept as being normal with hospitals?

Mr. PETTENGILL. There is a very substantial variation in physicians' charges from one area to another. Of course, in part it is due to the economic differences of the area. In part I suspect it is due to some traditional practices which the medical profession itself has; but you are correct—we do recognize a rather substantial variation in physicians' charges.

Mr. SCHNEEBELI. But isn't there also a variation within the same area depending on the length of service of the surgeon, let's say? A surgeon who has been in practice 25 years possibly might charge a little more because of his more highly specialized skill than somebody just coming into the practice. Is this accepted?

Mr. PETTENGILL. To the extent, sir, that he is a more skilled physician in the eyes of his peers—

Mr. SCHNEEBELI. Even though he lived in the same city and does the same work?

Mr. PETTENGILL. Even though he lives in the same city, if his peers recognize this distinction, we would recognize it.

Mr. SCHNEEBELI. Is this variation between physicians' charges greater than the difference between hospital charges?

Mr. PETTENGILL. This is a difficult question to answer. If you want an offhand guess I would say not as sharp as the differences between hospitals because with hospitals you have a tremendous variation in the amount of ancillary services provided and this makes a big difference in their cost.

Mr. SCHNEEBELI. Could you tell us an acceptable variation between the highest charge hospital and probably the lowest charge hospital by your experience that would be accepted?

Mr. PETTENGILL. That is almost impossible, sir.

Mr. SCHNEEBELI. Would there be as much as a 50- or 60-percent difference?

Mr. PETTENGILL. In the same city?

Mr. SCHNEEBELI. No, no, various parts of the country.

Mr. PETTENGILL. Yes, sir.

Mr. SCHNEEBELI. Does this variation amount to as much as 60 or 80 percent?

Mr. PETTENGILL. Without doing any research, and I would have to do some research to give you a valid answer to the question, I can say that I would expect to find almost a 100-percent difference.

Mr. SCHNEEBELI. Let me ask you another question. If you find that either the hospital or the physician's charges are exorbitant in your private practice how do you handle the case?

Mr. PETTENGILL. If this is a situation which we are discovering for the first time we would go to the appropriate medical society to get their advice as to whether they concurred with our judgment as to the prevailing charges in that community for that particular service, and I would like to say that they are in general very cooperative with us in this regard.

I think you can appreciate that if we have had many such experiences, why, then of course we might be applying our own judgment, but I would like to make this point clear. We go and talk with the physician first because in many cases you can appreciate that the statements which are submitted to us are not fully explanative of all the work that was done, so that in many cases the high charge is not a high charge when you evaluate all the services rendered.

Mr. SCHNEEBELI. You say you go to the physician. Is that your field man that does this?

Mr. PETTENGILL. That would be our field man that does, that is right.

Mr. SCHNEEBELI. Do you go through the same procedure in medicare charges? In cases where you think they are exorbitant do you go through the same procedure.

Mr. PETTENGILL. Correct, sir.

Mr. SCHNEEBELI. In other words, your method of operation under medicare is exactly the same as it is under your regular commercial work?

Mr. PETTENGILL. With this exception, sir; that under our regular business we feel able to rely on our own judgment in many cases without having to go back to the physician on something which is a borderline item, whereas thus far under medicare we get the impression that we are supposed to go back where it is a borderline case.

Mr. SCHNEEBELI. And I see you are recommending that the Social Security Administration take stock of your judgment more than they have up to the present time.

Mr. PETTENGILL. We would appreciate that, sir, yes, sir.

Mr. SCHNEEBELL. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Watts.

Mr. WATTS. Your companies issue policies to people under 65 that provide something equivalent to the service that is provided under section B of the Social Security Act, do they not, sir?

Mr. PETTENGILL. Actually it is a combined policy, sir, which covers both hospital and physician services.

Mr. WATTS. Do you have any statistics on whether or not charges of physicians to those people over 65 and those people under 65 had any comparability for the same types of service.

Mr. PETTENGILL. The law itself makes it quite explicit that we are not to recognize charges under medicare which are higher than those we would recognize for our own comparable business, so that I think all of us can assure you that we are most careful in this regard.

Obviously we do not check every single item, but we do have general checks in this regard and it is both for your protection and ours.

Mr. WATTS. I can see you are under obligation not to pay higher fees for medicare patients than you do for those that you insure yourself, but there is nothing in the law that prohibits a doctor from charging you more for those who are not under medicare. You are not prohibited from paying more, are you, for those that are under 65?

Mr. PETTENGILL. As far as we can see, sir, the physicians are being very fair and we have seen virtually no evidence of any differential between whether you are a medicare patient and whether you are not, with the possible exception, and I am not even sure that is true, of the absolute welfare patient.

Mr. WATTS. Of the what?

Mr. PETTENGILL. The absolute welfare patient where the physician was not making any charge at all.

Mr. WATTS. I am not assuming that the physician is being unfair about it. I merely asked you if you, in going through your statistics, and your familiarity with the operation of the company, had noticed a difference between the charges under one system versus the other.

Mr. PETTENGILL. The answer is "No," sir.

Mr. WATTS. With reference to hospitals, you issue policies comparable with those issued under part A, do you not? Not exactly alike, but you get the full hospital bill and determine what 80 percent of it would be, or something of that nature?

Mr. PETTENGILL. I do not believe there is a comparable requirement, but I think the gist of your question is do we see a difference between the charges to the medicare patients and those to the nonmedicare patients.

Mr. WATTS. Yes, sir.

Mr. PETTENGILL. And I have not seen any.

Mr. WATTS. There is no difference in the hospital charges as far as you can see?

Mr. PETTENGILL. Correct.

Mr. WATTS. In other words, both are paying about the same amount for the same service?

Mr. PETTENGILL. Well, provided the contract requires us to pay that. You realize we have all kinds of contracts, sir.

Mr. WATTS. I realize that, but take the comparable contract.

Mr. PETTENGILL. On the comparable contract we are paying comparable benefits.

Mr. WATTS. We did have an argument sometime back with the social security people, if I remember correctly, concerning whether there were certain items of charges that would go against a regular patient that probably wouldn't go against the medicare patient. They were supposed to recover the cost and so on and so forth, so if they are the same that argument we had didn't amount to anything, did it?

Mr. PETTENGILL. Excuse me, sir. I apologize for advising you incorrectly here. You were speaking with respect to the charges which the hospital is making. We see no difference there between under and over 65, between a privately insured plan and a medicare plan, but the medicare benefit is ultimately cost to the hospital and cost is as defined by the Social Security Administration, so that it is entirely possible that by reason of a private plan having paid 100 percent of the hospital's charges the hospital will end up in a different position than it will end up by reason of having ultimately collected 100 percent of the costs as defined by social security.

Mr. WATTS. That is what I was trying to get at. That is the reason I asked you if they were comparable, to find out whether or not they were operating on the basis of cost or on the basis of the full-scale cost of some items that were supposed to have been left out.

Mr. PETTENGILL. With respect to part B, because the benefits are in terms of charges and because our regular benefits are in terms of charges, those are comparable. With respect to part A our regular benefit is in terms of charges. The medicare benefit is in terms of cost, and we are seeing no difference in the charges the hospital makes, but the two benefits could be quite different.

Mr. WATTS. Then I assume from your answer with respect to the hospitalization end of it that you do pay the benefits for the social security people and get your money back. Is that the way you do it, or how do you work it?

Mr. PETTENGILL. You are referring to part A, sir?

Mr. WATTS. Part A.

Mr. PETTENGILL. Yes, the hospital sends us a bill. We are paying them under an interim agreement a figure which hopefully will represent their cost. At the end of the fiscal period we will go in and we will audit their records and determine their precise costs for the medicare program as defined by social security.

We will compare that with the sum of these interim payments and if the interim payments are too low we will pay an additional check. If the interim payments are too large the hospital will make a refund to the program.

Mr. WATTS. Then assuming that you were paying the claims of two persons, one over 65 under medicare and one under 65 not under medicare, and they both were furnished identical services, the bill that you would pay on the one under 65 would be a little larger than the bill that you would pay on the person 65 or over.

Mr. PETTENGILL. That would depend, sir, entirely on whether the hospital's charges were in excess of their costs or not.

Mr. WATTS. Well, assuming that they charge their total cost, would there be some difference between them ordinarily?

Mr. PETTENGILL. If the charges were set exactly equal to the hospital's idea of its own cost—

Mr. WATTS. In both cases they would be the same.

Mr. PETTENGILL (continuing). Then unless there is a difference between the social security definition of cost and the hospital's definition of cost they will be identical.

Mr. WATTS. Well, at the time we were writing the program, if I remember correctly, there were some items that there was quite a bit of question raised about, as to whether they should be included as an item of cost, but some hospitals did include them as items of cost.

Now, to go back, assuming that the two people were in the hospital where the hospital's figures on cost were different from the social security cost, would the bill be larger for the person under 65?

Mr. PETTENGILL. Sir, I am not trying to duck this question. I am merely saying that I think the answer is going to depend in each individual hospital circumstance on whether there are certain items the hospital considers to be a "cost" which are not considered to be—

Mr. WATTS. I am assuming that this same hospital figured a higher rate of cost than the social security people figured. Would the bill to the person under 65 be more or less than the one to the person who was 65?

Mr. PETTENGILL. In that instance it would be more.

Mr. WATTS. That is all I wanted you to say, sir.

Thank you.

The CHAIRMAN. Any further questions? Mr. Conable.

Mr. CONABLE. Mr. Pettengill, in your opinion is there adequate computer capacity at Baltimore?

Mr. PETTENGILL. Sir, I am not a computer expert and therefore, I don't think I can truthfully answer that question.

Mr. CONABLE. Is there any part of the program that isn't being processed as fast as some other parts of the program?

Mr. PETTENGILL. To the best of my knowledge, sir, the computers there have adequate capacity.

Mr. CONABLE. Is there any buildup with respect to outpatient claims? They require somewhat more complicated handling, don't they?

Mr. PETTENGILL. The outpatient claim is more complex to handle. I would ask my colleagues if I may.

Have you seen any difference in the operation?

Mr. WHITE. No.

Mr. PETTENGILL. As far as we are concerned Baltimore is not taking any longer to reply to a query with respect to the outpatient claim than it is with respect to the inpatient claim.

Mr. CONABLE. Was there a time at the inception of the program when outpatient claims built up considerably?

Mr. PETTENGILL. This, sir, I think, was because of the hospital itself. The hospitals found, and some of them still find, that it is much more complex to prepare the billing for the outpatient claim than it is to prepare the billing for the inpatient claim, so that the hospitals were taking longer to present these bills to the carriers.

Mr. CONABLE. With respect to part B you are suggesting a joint payment proposal here instead of refining the receipted bill. You have some experience in this field. Which type of procedure do you think

has greater possibilities for fraud on the part of the beneficiary? Do you find a lot of forgeries if you send out joint paychecks? Do you find occasionally that patients wheedle receipted bills out of physicians so they won't have to borrow money and then refuse to pay the physicians?

Which approach has greater difficulty from the point of view of policing?

Mr. PETTENGILL. I think you can appreciate that a person who is going to perpetrate a fraud is probably going to perpetrate the fraud no matter what system you design, and what we are proposing here is on the assumption that, for valid reasons, the use of just an itemized unreceipted bill is not permissible. This, you must understand, is our normal way of processing claims—we don't require a receipted bill; we just require an itemized bill, but assuming that that is not possible, then our suggestion is that you not eliminate either of the two methods that now exist, but that you add this third method which would permit this joint payment. We do not anticipate that there is going to be any significant fraud in connection with this introduction of a third method of payment.

Mr. CONABLE. Your experience indicates that generally?

Mr. PETTENGILL. Correct, sir.

Mr. CONABLE. You said the companies which you represent handle about 10 percent of the business.

Mr. PETTENGILL. Excuse me. I said we handle fewer than 10 percent of the hospitals for part A, but with respect to part B we are serving approximately 8 million of the beneficiaries.

Mr. CONABLE. What percentage is that?

Mr. PETTENGILL. Roughly 40 percent, sir.

Mr. CONABLE. May I ask if this is desirable business for you? Are you seeking this business, or do you find it something that is necessary but undesirable?

Mr. PETTENGILL. I think you can appreciate that the bill specifies we will only be paid for our "cost" in connection with doing this work. There is no element of profit. Indeed, there is no element to allow for the hidden expenses that we may uncover.

We are therefore doing this, gentlemen, as a public service.

Mr. CONABLE. Does it require more in the way of personnel than the processing of your normal claims or private claims?

Mr. PETTENGILL. It does for the reasons I have already stated, in addition to which it does because the statistical requirements under this program are substantially greater than those under our normal programs.

Mr. CONABLE. That is all, Mr. Chairman.

Mr. BURKE. Mr. Chairman.

Mr. CHAIRMAN. Mr. Burke.

Mr. BURKE. I don't know whether I got your answer to Mr. Ullman correctly or not, but he asked you about the trends of charges and how they were going and you indicated I believe you would not be able to give this committee that information because of contracts and that you could only give this to Health, Education, and Welfare.

In other words, this was privileged information that the Members of Congress would not be entitled to?

Mr. PETTENGILL. I didn't mean to imply that, sir. As far as being an intermediary or carrier is concerned, by contract is that I furnish the Secretary with what information he shall direct and what he does with it, of course, is his prerogative.

Mr. BURKE. How are we to decide on the recommendations you are making here in relation to reasonable charges if we are not given the information we should have? Of course this trend of charges is a most important item, whether or not the hospitals have increased the charges during the 8-month period in comparison to the previous year, whether the doctor and his office charges are going up.

I think we are entitled to this and I don't think the Health, Education, and Welfare Department or anyone else has the right to tell you that you cannot give this information to this committee. We are the committee that will vote on this matter.

Mr. PETTENGILL. Well, sir; the crucial fact is that because they were going to accumulate this data into their computer they specifically said in most instances that we were not to accumulate it into our computers because this would be double effort and we did not do so.

We are furnishing very detailed statistics to the Secretary and with due regard for his having time to process this data through his computer he should be able to give you, sir, what you want.

Mr. BURKE. But you have at your disposal figures indicating what the trends are. I doubt very much if any insurance company would be lacking this information. I don't mean you personally. I mean the carriers. The 15 carriers here must know because they are discussing what are reasonable charges and they certainly must have the information on what the trend is on these charges and how they are developing.

Mr. PETTENGILL. I think you can appreciate, sir, that in a particular community where I am privileged to serve as a part B carrier I am certainly sensitive to the changes.

Now, frequently of course the number of physicians is such that even in that community you don't have a smooth progression of your curve. It is an erratic curve because some doctors will change today and then won't change their fees again for several years, so that in any one community we get a rather erratic picture.

I think the thing that you are primarily concerned with is the overall picture which would be the composite of all 50 carriers and not the picture of just one carrier.

Mr. BURKE. There was a cartoon in one of the newspapers here either yesterday or today apparently showing a member of the family of the patient who was in the hospital and the member was saying to the patient, "We are having you transferred to the Waldorf Astoria. It is much cheaper there."

I think that was Herblock. But it is important to us to have the information specifically from your group and some other groups so that we can compare how the different carriers are being affected. I depend a lot on the Health, Education, and Welfare Department for their information, but we would like to have the information from your group, also. I doubt very much if Health, Education, and Welfare will tell you not to give us that information. I think we are entitled to it.

Mr. PETTENGILL. In this particular instance, sir, it isn't a question of whether I can or cannot. At the moment because of the nature of the arrangement I do not have it.

Mr. BURKE. I am not asking for it right at the moment, but it is my opinion that the 15 carriers that are represented here in this testimony must have some information about the trends as to the charges and how they have been going during the 8-month period of the operation of this law, and at some later date before these hearings are concluded I think the committee would like to have it. It would like to have it, anyway.

Mr. PETTENGILL. I appreciate it, sir.

The CHAIRMAN. On that point, Mr. Pettengill, it is not that you are told not to give us information. It is just that you do not have the information. Is that right?

Mr. PETTEGILL. That is correct, sir.

The CHAIRMAN. And unless we have prompter action by HEW than we have had up to date with respect to this matter we may have difficulty getting it for use in executive session. I understand that the HEW sample of costs and charges is not even complete yet for the month of July.

Mr. BURKE. Mr. Chairman, I am merely pointing out that in his answer to Mr. Ullman he indicated, because of a contract, that he had been instructed by Health, Education, and Welfare not to give this information.

Mr. HAWKINS. No.

The CHAIRMAN. That isn't true, is it?

Mr. PETTENGILL. No.

Mr. BURKE. This would be surprising to me.

Mr. PETTENGILL. I am sorry you misunderstood me, sir. It is the information that I am to give to the Secretary and, of course, I think you can appreciate that I would not in any event, even if I didn't have a contract, go around divulging confidential information where it shouldn't be divulged.

The CHAIRMAN. Is my observation right about the HEW sample for July? Is that out or not?

Mr. PETTENGILL. I have not seen any figures, sir.

The CHAIRMAN. You would have seen them, wouldn't you?

Mr. PETTENGILL. Well, they are not under obligation to give them to me.

The CHAIRMAN. We will find out; but it is my understanding that they are not yet available for the month of July 1966, the first month of the program.

Any other questions?

Mrs. GRIFFITHS. Mr. Chairman.

The CHAIRMAN. Mrs. Griffiths.

Mrs. GRIFFITHS. One of the largest complaints I have had, Mr. Chairman, is the doctor insists that the patient pay his bill. He pays the bill, sends it in to the carrier, and when it is returned the doctor's fee has been cut down \$100 or \$150.

Will this joint payment to the doctor and patient help take care of this or won't it?

Mr. PETTENGILL. As I mentioned in connection with our proposal, this joint payment would not in any way affect the physician's right

to charge the fee to the patient which he thought was proper. The carrier would be making, of course, its determination of a reasonable charge and it is conceivable that under certain circumstances the benefits would be based on an amount lower than the physician actually charged.

Mrs. GRIFFITHS. I observed in your testimony that you said that you inquire about that exact doctor's usual charge. Is that right?

Mr. PETTENGILL. This is the intent of Social Security that we do so; yes.

Mrs. GRIFFITHS. I had a case where I believe the doctor had charged \$550 for removing the voice box, the vocal cords, and so forth and so on. They would permit the patient only \$450.

On inquiry I discovered that the normal charge is \$750. Why would that happen?

Mr. PETTENGILL. That is an individual case, Mrs. Griffiths, and you would have to take it up with the particular carrier concerned.

Mrs. GRIFFITHS. Well, this is the biggest complaint I have had from constituents, not alone that they are not being paid reasonably rapidly, but they are not being reimbursed for what they pay.

Mr. PETTENGILL. I can appreciate your problem; but it would be an individual problem with a specific carrier.

Mrs. GRIFFITHS. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Again, Mr. Pettengill, and those at the table with you, we thank you very much for coming to the committee. We may be back in contact with you later for some additional information.

Mr. PETTENGILL. Thank you, sir.

The CHAIRMAN. Thank you very much.

Mr. McNerney you have been before the committee on several occasions in the past, but for purposes of this record will you again identify yourself?

STATEMENT OF WALTER J. McNERNEY, PRESIDENT, BLUE CROSS ASSOCIATION

Mr. McNERNEY. Mr. Chairman, my name is Walter J. McNerney. I am president of the Blue Cross Association, the national organization of Blue Cross hospital service plans. It is a pleasure and a privilege to appear here as a representative of these plans.

The implementation of Public Law 89-97, titles XVIII and XIX has been a massive undertaking. As an intermediary under both programs, Blue Cross has shared in the implementation. This experience has revealed some administrative problems related to complexities of the law and the benefit patterns and the application of a highly uniform set of regulations to a variegated health system.

Under title XVIII, Blue Cross recommends a simplification of the ambulatory benefits, an easy to administer yet equitable program of payment to physicians working under a contract with a hospital, an amendment dealing with confidentiality of records, and elimination of initial certification of necessity of admission by a physician. Other recommendations deal largely with the desirability of basing the system on greater use of objectives and criteria, with some flexibility of

performance on the part of providers and intermediaries, so as to speed workflow and bring the decisionmaking process closer to the manifold problems that arise on a daily basis, as opposed to use of a tight set of prescriptions which inevitably cut across a wide variety of local capacities and practices.

The amendments offered under title XIX are generally supported. Particularly appropriate is the provision in H.R. 5710 which limits Federal participation in the program to those persons whose income does not exceed a certain amount, which varies by State. Assuming that these amounts are sensitively set, there will emerge a sound meeting ground of Government assistance programs and an expanding system of voluntary prepayment.

Collectively, Blue Cross plans provide benefits to approximately 64 million persons in the United States including more than 4 million Federal employees and dependents. Also, Blue Cross acts as an intermediary for over 93 percent of the participating hospitals, 84 percent of the home health agencies, and more than 55 percent of the extended care facilities participating under title XVIII of the Social Security Act; it is serving a growing number of States, now 24, under welfare programs such as those under title XIX, of the Social Security Act or supplements to title XVIII benefits for welfare recipients; it administers benefits in 33 States under the civilian health and medical program of the uniformed services; and it has accepted certain administrative responsibilities under the VISTA program.

Eliminating the overlaps, we serve nearly 45 percent of the population in one way or another. Furthermore, Blue Cross experience extends to all age groups, many types of health benefit structures and to all sections of the country.

I should like to comment on various facets of H.R. 5710, including title I: Old-Age, Survivors, Disability, and Health Insurance and title II: Public Welfare Amendments.

COMMENTS ON TITLE I

The health insurance for the aged program enacted under Public Law 89-97 is a large and complex undertaking, involving approximately 20 million aged citizens, a multitude of general hospitals, home health agencies, and extended care facilities, the vast majority of practicing physicians in our country, numerous private health insurance and prepayment carriers and the extensive resources of the Department of Health, Education, and Welfare. It started successfully on July 1, 1966, but it is still very much in the formative stages.

The accomplishments of the program, for which members of this committee and the staff of HEW can take satisfaction, are a matter of record. However, one must expect that problems will arise in the administration of a program of such magnitude. I am sure it was no surprise to any of us to learn that this expectation had materialized. Some of the problems stem from the law itself; others are the result of administrative interpretation and implementation.

My comments are directed largely toward what we in Blue Cross believe are the principal legislative and administrative factors in need of change and what changes are called for.

Before proceeding, let me call your attention to appendix I. In it we have tried to spell out in brief terms the major steps involved in the claims administration process, hoping that a perusal of it would make my remarks to follow more meaningful. Although the function of claims administration is, at first glance, a routine process, it can, in fact, be everything from a facilitative process to an impediment depending on its design.

Simplification

A major need of the program is for simplification. The present benefits are too complex to administer without excessive paperwork, cost, and time. They invite error. They are confusing to aged beneficiaries. Some benefits are so minor that bills can result in less value than the cost of issuing the check made in payment.

This situation is not caused by any one factor, but by several which do not mesh with each other and which in total do not fit well into the existing system for providing health care. Standing alone, no one of these factors would be a great problem, but in combination they cause slower and more costly claims handling than should be the case.

The \$50 annual part B deductible

An important administrative complexity arises from the \$50 deductible under part B. As part A intermediaries, Blue Cross is directly involved in the deductible because we administer several elements in part B benefits, such as for outpatient and home health services. To some extent the proposals in H.R. 5710 called part C have reduced this complexity, while introducing some, as we will comment on later.

The basic complication arises from adoption in the act of some principles of the service benefit approach of nonprofit prepayment plus some principles of the indemnity major medical approach of commercial insurance, which don't mesh well.

Medicare wants to provide coverage at the time care is rendered, and so hospitals are paid directly and physicians are urged to accept assignments. This is desirable. But, it is not compatible with the concept that the first \$50 of benefits under part B will not be covered at all, because records must be kept of those \$50 so that the hospitals and home health agencies can know when the obligation has been met.

Under a more familiar major medical approach using the deductible, only a small percentage of the population gets involved because the deductible is in the form of a corridor after the application of basic hospital and physician benefits.

In any case, the beneficiary normally keeps the records of his expense until the deductible is met.

Under medicare, having to search the central record in Baltimore to update the deductible, and to delay the application of medicare credits until the information is available introduces complexities.

Further administrative complexities result from (1) the fact that the deductible can be fulfilled by charges submitted to a variety of intermediaries and carriers by a variety of providers, physicians, or beneficiaries; (2) the provider does not have adequate knowledge of the status of the deductible when small and short-term benefits are involved, as in outpatient services; and (3) the requirement that ex-

penses incurred in the fourth calendar quarter of a year and applicable to that year's deductible are also "carried over" and made applicable to the following year's deductible in an effort to achieve greater equity among beneficiaries.

Parenthetically, while we do not believe that it has any favorable or even noticeable effect on utilization of hospital care, the \$40 deductible in each spell of illness under part A has not proved to be a special administrative problem, either to the hospitals or to the intermediaries.

The administrative system has been able to accommodate it, largely because most hospital bills exceed \$40 and involve only one provider. Eventually, we will need to determine whether there have been serious problems in collecting the \$40 but so far the reports of such difficulty have been minor.

Outpatient services

This is an awfully important area to understand. I am sure that the committee has heard something on it already.

The present program sets up a third form of deductible—this is for diagnostic benefits—(\$20 in addition to the basic part A \$40 and the part B \$50). It sets up a third time period during which charges must be accumulated (a 20-day span in each hospital used by the beneficiary, in addition to the spell of illness period in part A and the calendar year in part B).

It makes the \$20 deductible applicable against the part B \$50 deductible and limits the amount of \$20 deductibles to \$50 in a given year.

In other words, they interact. It requires completion of an exceptionally complicated claim form by the hospital, generally for a benefit that does not average more than the cost of preparing the form. We have seen copies of benefit checks for 1 cent.

Some gross figures from the first 7 months of medicare will help to demonstrate the present situation:

Under part A, Blue Cross processed 541,769 outpatient claims, of which 321,610 involved no payment under the program.

Under part B, Blue Cross processed 468,698 outpatient claims, of which 264,859 involved no payment under the program. In total, out of more than 1 million outpatient claims, nearly 60 percent resulted in no medicare benefits.

Yet, claim forms were required to be submitted by the provider of services and to be forwarded to Baltimore by the intermediary.

In addition, as stated earlier, the average benefit is a matter of a few dollars at best, possibly something over \$4. And finally, there are indications that a significant portion of this very substantial iceberg may still be under water.

Projecting partial reports from Blue Cross plans, there may be as many as 750 hospitals which have never submitted any, or only a few, outpatient claims since the start of the program, because of the complexities of reporting and the difficulty of knowing how to calculate the benefit, and there may be as many as another 400,000 claims never submitted at all. Many of these would involve no benefit, but some of them would, and to that extent the medicare beneficiary may have lost a benefit to which he is entitled.

Note, too, that to the extent not reported or reported late the amounts involved affect the \$50 part B deductible. This could mean that many

beneficiaries have actually satisfied the \$50 deductible at an earlier time than shows up on the record in Baltimore.

A further complexity involves the necessity to make an often difficult distinction between diagnostic and therapeutic services in the outpatient department, which must be recorded separately on the bill of charges for part A and part B, for a single case.

There is a picture of complexity that must be dealt with.

Arrangements between hospitals and physicians

Over the years there have evolved various arrangements whereby physicians work under a contract with a hospital. These arrangements must always be acceptable to the physician involved, and sometimes the medical staff of the hospital as well, and we conceive them to have been entered into freely and to be acceptable to all parties involved.

Generally, the services of such physicians are considered a part of hospital costs and are invariably paid for as such by private organizations like Blue Cross. It is only in those instances where the bill is clearly that of the physician, that Blue Cross does not pay. In such instances the bill would be paid, for example, by Blue Shield.

Thus, over the years, the cost of such services has been treated as a hospital cost or as a physician cost depending upon who submitted the bill, and the whole billing and prepayment system is geared to that procedure.

Notwithstanding this well-defined and workable system, however, medicare requires that charges for services rendered by such physicians be determined separately from costs incurred by hospitals for inpatient and outpatient services, even if, in fact, the physician receives his compensation in the form of salary or percentage payments from the hospital and not from direct billings to the patients.

This required split between the so-called professional component of care and the administrative component has caused difficulties in its computation, has been disruptive of relations between doctors and hospitals, has required the submission of two bills by the hospital, one to the intermediary and one to a carrier, where normally one is sufficient, has doubled the amount of information which must be sent to Baltimore for recording in the history record, has resulted in some unrealistically small bills and has raised the possibility of greater cost to the program.

COMMENT ON PART C OF H.R. 5710

Part C is in the bill as a proposed device to ameliorate some of the above problems. It is a marked improvement over the present system.

However, as we read H.R. 5710 the effort to cure these problems by a new part C, goes only part way toward the objective, and introduces new complications. As we understand it, the intention of part C is as follows:

(1) Where the hospital bills for outpatient services, the billing would include costs to the hospital for both institutional services and the services of radiologists and pathologists. The entire billing would be reimbursed by the part A intermediary out of the part B fund, and the \$50 deductible and the 20-percent coinsurance would apply.

This proposal would remove the third-form concept of deductibility and benefit period (\$20 in 20 days) as well as the artificial distinction

between diagnostic and therapeutic hospital service; both of these changes are much to be desired. The proposal would only partially remove the existing problem of separating out the charges for professional services, because the change applies only to radiology and pathology. It would still be necessary, for example, to determine separately and bill separately for the services of the cardiologist and physiatrist, who are compensated by the hospital directly under an arrangement.

The proposal would withdraw outpatient benefits from part A beneficiaries who have not signed up for part B and would continue the administrative problems related to the \$50 deductible.

Under the part C proposal, all outpatient claims would be subject to the \$50 deductible, and it would never or seldom be possible for a provider to determine patient liability at the time this care was rendered. This does not provide the simplification which we believe is essential.

(2) Where the hospital bills for inpatient services, the billing would include costs to the hospital for both institutional services and the services of radiologists and pathologists. The entire billing would be reimbursed by the part A intermediary out of the part A fund.

As we understand it, also, the charges for the speciality services would not be subject to the regular \$40 deductible on part A benefits, or to the \$50 deductible applied to part B benefits. This would be an equitable result so far as all parties are concerned, but introduces an administrative complexity. Because the services will be partly included in a hospital's cost, but not subject to the deductible, the billing procedure will require further manual completion.

It will make it necessary to state separately the costs of the departments involved in diagnostic laboratory and radiology, and other diagnostic services (but not therapeutic radiology, for instance) and to report these charges on each individual claim form, and only apply the \$40 deductible to other charges of the hospital.

It is possible to determine these costs, readily enough, for reimbursement or audit purposes. But to require that they be interpreted and applied to each individual claim form because these particular services are exempted from the deductible is just as bad in reverse as placing them under a separate deductible—in fact, no deductible is a “separate deductible.”

As in the case of outpatient services, the proposal only partially solves the so-called professional component problem of separation of charges. The change is limited to radiology and pathology and retains the necessity for separate billing for other professionals, for example cardiologists.

(3) Where the physician (not limited to radiologist and pathologist) bills the patient directly, or, under assignment, bills the medicare program for his services, reimbursement would be made by the part B carrier out of the part B fund.

As we understand it, the reasonable charge would include not only the physician's personal service to the patient, but any administrative service as well. We further understand that the charges would not be subject to the \$50 deductible or coinsurance.

The proposal here follows the tradition of “pay whoever bills,” and we support this concept. While it is not our direct concern as a part-A

intermediary, we foresee possible difficulties in sorting out those charges which are not subject to the deductible, and those that are.

For example, those that might emanate from the offices as opposed to the hospital.

RECOMMENDATIONS

The following recommendations, which we think this committee might weigh carefully, are calculated to simplify the system further than part C does and to provide an important simplification, important certainly to the aged themselves in comprehending what their benefits are at the time of illness.

(1) We recommend that immediate consideration be given to a change in the benefit pattern of part B. We suggest that the \$50—part-B deductible be replaced by a co-pay requirement under which the beneficiary will always pay a stated percentage or minimum dollar amount of every individual charge incurred, making it unnecessary to keep records on the extent to which the deductible has been met by the wide variety of charges which can apply against it.

We realize that this suggestion will require more money. If, however, the contributions from the Government and the beneficiary have to be raised and/or the beneficiaries' copayment increased in order to eliminate the deductibles, let this be done. We think it would be worth doing to make the present program work well and be comprehensible to the aged. It should have high priority.

(2) We recommend that all hospital outpatient services be part-A benefits subject to a straight 50-percent copayment by the beneficiary but with a maximum payment of \$20 for any series of related billings by the same hospital, and a minimum billable medicare benefit of \$2 (to avoid the processing of the small miniscule expenses). Incidentally, they can be paid through reimbursement cost.

(3) We recommend that all services billed for by the hospital, including those services of physicians rendered to an inpatient or to an outpatient but which are hospital receivables should be covered under part A and reimbursed on the basis of reasonable costs to the hospital as for all other hospital-billed services. This is the customary practice in Blue Cross and Blue Shield for several million Americans.

(4) We recommend that services of physicians billed for by the physicians, or in his name by any other entity including a hospital, would be covered only under part B on the basis of reasonable charges, whether for services rendered to an outpatient or to an inpatient. This is also customary practice.

It might be well to safeguard the interests of the individual doctor, as the American Medical Association's House of Delegates proposed during its last meeting, by stipulating that the individual doctor and the medical staff agree to the contract. In this manner the professional status of the doctor, local determination, and program simplification are all protected.

COMMENTS ON OTHER PROPOSALS IN TITLE I

Regarding other proposals in title I, and I would repeat again, we consider those primary, we offer the following comments.

Section 131, part 3. Eliminate physician certification of necessity

We endorse the provisions of this section. This change will also ease an administrative burden; and, equally important, it will make more meaningful the recertification and utilization reviews for which provision is still made.

The present requirement of written certification of need by the physician upon admission to the hospital as an inpatient or outpatient has been met with such far-fetched responses as the physician's signature being affixed to a sheet on the back of which is stamped a statement of need which he needn't see.

The cynicism that stems from this is apt to contaminate more substantive controls such as utilization review and careful claims administration, and encourage paper responses instead of meaningful control programs.

We hope that recertification would not be required by regulation prior to the 20th day. Some consideration might be given, in fact, to stating this in clause (B) on page 72 in the reverse of this present expression, that is ". . . and (B the first such certification required under clause (A) shall not be required earlier than the 20th day of each period;"

Section 161, part 4, title I. Interns and residents

We endorse this proposal. However, we again urge that consideration be given to including additionally a provision for coverage of the reasonable costs of other physicians including those who function in a teaching or a supervisory situation, perhaps director of education, within a hospital and who do not render bills privately for those services to persons who are involved as patients there. This would be taken care of if you bought the proposition that however bills get paid, but as a separate issue I might add that there are physicians who fall outside the interns, residents, or those practicing with limited license who in fact are in an administrative teaching capacity that should be folded into the same idea.

Section 164, part 4, title I. Limitation on reduction of 90 days

In the interest of equity among patients, we would favor the entire elimination of the provisions of section 1812(c) as to reduction of days, rather than the proposed clarification suggested here.

Section 125, part 3. Care for the disabled

We endorse the objective of this section. I want to add, however, that the medical needs of these persons differ from those of the aged. Among the disabled one is apt to find greater need for mental care, long-term care, and rehabilitation services, for example.

There are measurable differences in the needs among the disabled. As the Social Security Administration points out in one of its studies. (1):

The younger disabled, with a high proportion of mental disease, had a higher proportion hospitalized at some time during the survey year, were hospitalized for a longer period during the survey year, and had a greater proportion in long-stay hospitals than the older disabled workers.

These people need assistance, but the combination of differences suggests the greater usefulness of an earmarked cash allowance for the

purchase of care; the development of appropriate benefits under title of XIX of the Social Security Act; or the establishment of a special disability health care program administered separately on a cost basis by a private carrier as under the Federal employees retiree program thus permitting the disabled to tailor the benefits more to their individual needs through the device of alternative programs.

The idea would be to get a set of benefits more extensively tuned rather than using those that now exist.

Section 126, part 3. Payment to Federal facilities

To date, Federal facilities have not been integrated well into such planning as exists among hospitals presently at the local level. Determinations as to whether to expand or contract these facilities are made at distant points related to extra-local as well as local factors.

Duplication of effort between voluntary or local government and Federal hospitals can result. Before Federal hospitals are paid like other hospitals their status relative to local planning should be made clear. This matter is subject to study by the AHA and the Government.

In our view action should be withheld until such study is completed and public policy has been enunciated on the subject. The Federal Government should not be exempt from the same considerations now being weighed against local providers and it should not duplicate the care now being rendered by existing facilities and programs.

One should take cognizance of the fact that the Secretary can pay for care in these facilities under the present act as long as the care is customarily given as a community service and for emergency care.

Also, if Federal hospitals are to be used as research centers to improve health care, as has been suggested, the question arises, also, if whether they should be used on a patient request basis.

There are two or three policy issues here, I think should be looked at.

Section 129, part 3, depreciation allowances

I want to say first of all that Blue Cross supports emphatically regional planning of health facilities. In one form or another, through financing, supply of data, et cetera, Blue Cross has participated in the steady growth of planning agencies in this country. It is estimated that there were five agencies operating in 1954. Today there are 75 to 80 with over 40 percent of the population affected.

More needs to be done in the light of rising costs and health manpower shortages. The capital structure of health services is unquestionably an important factor in achieving more productivity. Blue Cross subscribers and others will benefit from a rapid expansion of planning activity.

The proposal now before the committee in effect mandates funding of depreciation and expenditure of such money under title XVIII according to some kind of State plan. The general intent of this provision to promote planning is laudable, but we think that the provision per se is unwise. Not just the aged have a vested interest in planning, all ages do.

A proposal on planning as part of a broad complex piece of legislation dealing with the aged cannot in our opinion be adequately explored. Planning in itself is a complex subject. There is broad con-

census regarding the need for it, but much less consensus regarding the form it should take.

In his special message to the Congress on health and education, President Johnson spoke of appointing an advisory commission on health facilities to study the country's needs for a system of health facilities and of increased expenditures for research and development in health services.

We feel that the American Hospital Association should work with the Government on an intensive study which would lead to definitive recommendations on how planning should be structured and, in everyday terms, how it should operate elaborating in effect on Public Law 89-749, the amendments to the Public Health Service Act, which deal with planning at the State level.

Such a study should also bear on the subject of reimbursement. Administrators in many other sectors of the economy often use cash generated by depreciation for operating purposes. I think all who are in administration are aware of this.

If such depreciation funds are not available for current use, what amount is needed to finance replacement and additions of minor equipment, to finance additional accounts receivables, and handle other conditions normally found in a well-run institution? The subjects of planning and reimbursement are inevitably linked. If planning is to result in fewer, presumably needed, institutions then these must be fully paid. Less than full payment can be justified in an economic sense only in the absence of capital discipline through planning.

OTHER MATTERS

Complementary coverage

In my testimony before the Senate Finance Committee on May 5, 1965, I indicated that the Blue Cross system, prior to enactment of Public Law 89-97, provided coverage for approximately 5.6 million of the aged population. With the introduction of medicare, we faced the challenge of providing complementary benefits to take up the slack of deductibles, coinsurance, limited days, et cetera, and also of maintaining our high level of benefits for both group and individual members.

Recent reports show that Blue Cross has met the challenge. Our statistics indicate that approximately 4.8 million of the aged are already covered by complementary contract offered throughout the system as opposed to the 5.6 million we had before the act started. This represents approximately 87 percent of the premedicare figure, and is based on the supplementary contracts only.

Others are covered under other types of programs (e.g., basic coverage) and this unknown figure would obviously raise the percentage even higher.

Reimbursement of providers

I should like to comment on the administration of the current system of reimbursement of hospitals under title XVIII, referred to as the RCCAC concept (relationship of charges to charges applied to costs) under the general theme of simplification.

The system is costly to administer. It has required additional employees among providers and among intermediaries auditing more extensive data. It poses difficult questions for providers with all-inclusive

rates, and therefore no charge centers. And, it makes heavy demands on the cost-finding capacities of many hospitals.

Symptomatic of the complexities involved is the fact that accurate summary data are not available yet, upon which to base final settlements with providers whose year ending was September 30, 1966. Also, some cost reporting forms and reimbursement manuals are not yet available and audit subcontracts lack approval.

Other reasons can be advanced for modifying the RCCAC formula, but its administrative feasibility should be considered. If current practices in the health field were more closely followed there would be fewer problems.

It would be well to permit the protracted use of gross RCCAC, or average per diem cost methods, for effecting final settlement in situations where provider charging methods or financial records indicate.

Currently HEW and AHA are examining the RCCAC method of allocation. Perhaps out of this a sound long-range solution will emerge.

Another word on the need for flexibility should be added. The "current financing" formula is complex. For example, it requires the gathering of extensive information and the recomputation of amounts each quarter. And, it leaves little or no room for the intermediary to exercise judgment to meet the needs arising from changing local conditions.

Confidentiality of records

The concepts of confidentiality of title XVIII claims data are defined in regulations No. 1 under the Social Security Act, and a proposed amendment to the regulation which has been published for comment but not yet finalized.

The public interest here lies in seeing that administration of title XVIII, title XIX and other welfare programs, and the complementary coverage provided by the Blue Cross system and the insurance industry are coordinated with a high degree of efficiency at the lowest administrative cost.

The essential present problem stems from the requirements of the regulation, which calls for the beneficiary and the provider to consent to the release of title XVIII information. We have commented that the regulation is too restrictive. SSA has developed a proposed procedure for implementing the regulation and our reaction has been generally favorable, but our reservations are based on the assumption that the consent requirements would still be binding.

As things stand now even though we might be administering XVIII benefits and the complementary benefits, we are not supposed to look at the XVIII benefits to move them together sensitively with the complementary benefits to minimize the confusion of the aged beneficiary. We think that this committee should endorse every effort to be sure that we can use these data. The important thing is that the aged person when he is ill has this work done for him and not be caught in the bind as to how his benefits fit together.

RECOMMENDATION

We recommend that the consent clause which is standard in most, if not all, Blue Cross and insurance contracts, be considered suffi-

cient consent to share title XVIII claims information for complementary purposes. The provider consent is not required by all State statutes, but where it is, we recommend that the consent be made part of the hospital agreement with SSA, or that the intermediary secure a blanket statement of consent from its providers.

If there is concern that the present legislative reference is too restrictive to allow this latitude, we recommend that the Congress amend section 1106(a) (42 U.S.C. 1306) (a) by adding the following before the last sentence thereof:

Such Regulations shall provide that information in respect to any person who has received benefits provided under Title XVIII or Title XIX of this Act, acquired by an agency, organization or carrier with which the Secretary has entered into an Agreement as provided in Sec. 1816 or Sec. 1942, may be used by such agency, organization or carrier and made available to any other agencies, organizations and carriers as the Secretary shall approve, for the purpose of administering any health insurance contract or program covering such persons.

Claims processing

Under existing part A procedures, one of a prescribed series of claim forms must be completed by the provider for each episode of service, and then moved from provider to intermediary to SSA. Stemming from the requirement of a prescribed claim form is a series of problems affecting both efficiency and administrative cost:

1. The movement of paper forms for 100 percent of the cases creates a monumental task of paper pushing which is costly and hampered at all points by shortages in skilled manpower.

2. The requirement that the provider complete the special form differs with many existing procedures between providers and Blue Cross for transmitting claims information.

3. The scope of data solicited on the form commingles utilization information necessary for daily claims operation, and statistical information necessary for a variety of other purposes (e.g., utilization review, program evaluation, annual reimbursement). The former has immediate urgency on a daily basis, while the latter can be compiled in a more leisurely fashion. The mixture tends to delay the accomplishment of both.

4. The transmission of paper forms precludes the full and efficient use of existing sophisticated EDP and telecommunications system. We have initiated discussions with SSA, moving toward simplification of these problems.

For example, the hospital would transmit stipulated information in a variety of ways (e.g., tape, wire, or machine billing). The intermediary could transmit tape or punched cards, or could telecommunicate the necessary claims information to Baltimore. Statistical (research, reimbursement) needs could be met on a sample and/or retrospective basis. This would speed things up at no loss to quality.

Make full use of the intermediary

Some of the administrative problems of medicare in its first year stem from the fact of detailed, uniform regulations, interpretations and rules imposed quickly on a very diverse industry. Blue Cross and other health-care underwriters have experience and expertise in administering large health-care programs. That experience should be exploited.

Recognizing the need for HEW to be sensitive to standards and equity, it would be well if national regulation could be modified by a system which specified objectives and set minimum requirements for the data and reports that must be gathered centrally, relying heavily on audit to demonstrate performance, with the intermediaries held fully responsible for their acts. Some of this is being done; for example, in the areas of audit and utilization review. More needs to be done in areas such as emergency financing and in those already mentioned.

Such a modification should speed workflow and put decisionmaking closer to the everyday problems involved, without compromising quality of performance. Further, and importantly, it would improve beneficiary relations and understanding.

COMMENTS ON TITLE II

I should like to add a few comments about the public welfare amendments, specifically a few sections of title II of H.R. 5710 which are amendments to the provisions of title XIX of the Social Security Act.

Blue Cross has a strong interest in this title of the law. This interest is related both to assisting States to administer the State plan and in meeting the needs and demands of people who are able to provide for their health care through normal prepayment or self-budgeting.

Blue Cross and/or Blue Shield plans are involved in medical vendor payments for welfare recipients in 24 States. We have a great interest in it. Of these, in seven States Blue Cross is administering the hospital benefit program for all eligible recipients. In the other 17 States, plans administer supplemental payments over title XVIII for aged recipients. This includes deductibles and copayments when these are covered by the States.

Our position in regard to selected changes in the law is as follows:

Section 220, part 2 limitation on medical participation in medical assistance—We favor this provision which will remove the open-ended nature of the title XIX Law and provide an equitable meeting ground between the public and private programs.

However, there is a potential problem in using the highest income standard among the various cash assistance programs, this may be a program involving the fewest number of persons, whose needs would exceed or in some way only be accidentally related to the needs of others. Perhaps a better approach would be to use the income standards of the cash assistance program involving the greatest number of persons.

Section 222, part 2, coordination of title XIX and the supplementary medical insurance program—We are in favor of the provisions to include medical assistance recipients 65 or older under the buy-in for part B of medicare.

However, the exclusion of Federal participation in expenditures for services covered under part B if the individual eligible for medical assistance is not enrolled may create administrative problems because the medically indigent person may not be eligible until medical care is under way.

As a result, for anyone who does not apply in advance for and become accepted as being a medical assistance recipient, and who has not pur-

chased part B on his own, the State will have to pay the full cost of physicians' care for the first 2 or 3 months in which care is received until part B becomes applicable. This part of sec. 222 could be revised to remove the burden this will place on the State or on the individual.

Sec. 224, part 2, extent of Federal financial participation in certain administrative expenses—We support the equal treatment in regard to Federal participation in the administrative costs of personnel without the requirement that they be employees of the single State agency responsible for administration of the title XIX plan, whether it is welfare or otherwise.

Sec. 225, part 3, advisory council—We support the establishment of this council and urge that it include fair representation from every aspect of medical care and medical care economics.

In regard to the general administration of title XIX, we urge that the regulations established under it and title XVIII be similar, for the sake of greater predictability and comprehensibility on the part of all parties concerned. Some differences should be maintained for the sake of comparison and evaluation; for example, standards for acceptability of general hospitals might be identical, whereas reimbursement formulae, an area now lacking broad consensus, might differ experimentally.

In closing, let me say that I think that the recommendations we make to streamline, to simplify the procedures under the program, without any compromise to its integrity are extremely important, but I also would not like to close without saying that there are some environmental situations that are going to deserve all of our concerted attention, two especially, i.e., productivity and manpower.

One should be mentioned here. Every effort must be made to achieve greater productivity within our health system. A significant share of the gross national product is devoted to health, and the amount is rising. There is a limit to the amount, however. As we approach it, the desire of the population for service will be translated increasingly into getting more service out of whatever limited resources are available.

A recent HEW report to the President (Medical Care Prices) points out that a 4 percent increase in doctor productivity would add the equivalent of 11,700 doctors to the nation's supply, more than the total annual output of our medical schools. We must work together in developing a reasonable structure governing capital growth, in fashioning incentives for efficiency which can be built into everyday operations, and in experimenting with various forms of rendering care.

Blue Cross sees the need to broaden its benefits to encourage patient mobility among alternate services, and the need to participate actively in areawide programs designed to enhance the provider system as well as the individual provider.

We are prepared to participate in these developments, as well as to help improve the implementation of titles 18 and 19.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. McNerney, for your discussion of this matter. Without objection the material appended to your statement will be made a part of the record.

THE CLAIMS PROCESS

Following is a general description of the administrative steps required, under the existing program, to effectuate the delivery of benefits and to record the utilization history for the various episodes which the beneficiary can experience.

HOSPITAL OUT-PATIENT SERVICES

Services can be initiated either at the request of a physician, or as the result of circumstances, such as an accident case requiring ambulatory care. The patient presents himself at the out-patient department, and in the routine case, is able to identify himself properly as a Medicare beneficiary. If not, special procedures are followed, to search out the proper Identification number, through the District Office, Regional Payment Center, or in the various reference files at the SSA central office.

The claim is not presented to the Intermediary until the service has been rendered, and therefore demands caution in obtaining proper identity. The provider must make the following judgments in order to bill properly for the services:

1. If the ambulatory care were initiated exclusively for diagnostic reasons, the appropriate charges are recorded on the special SSA Out-Patient form in the area reserved for Part A charges. Since the diagnostic benefit is related to a 20-day study period, the provider should wait for 20 days, or if it bills on an interim basis, it must control the accounting record for this episode to be certain that the \$20 deductible is applied only once in a 20-day period.

2. If the care was initiated solely for therapeutic reasons, the appropriate charges are recorded on the billing form in the area reserved for Part B charges, and released to the Intermediary.

3. If the case primarily involves therapeutic services, but in the course of treatment one or more diagnostic services are appropriate (e.g., X-ray), the provider must separate the charges between Part A and Part B.

4. If any of the services described in 1, 2 or 3 involves the personal service of a hospital-based physician, a further split-out of these charges must be made and recorded on the form to reduce the gross charges to net hospital charges for Part A, Part B, or both, depending on the circumstances.

5. Depending on the billing arrangement between the provider and physician (assignment or direct), the provider may also be required to complete a special SSA billing form for the physician's charges; where applicable, this form accompanies the hospital form to the Intermediary and is then sent to the Part B Carrier for adjudication and payment.

6. The provider must also make a judgment as to the amount of deductible and/or coinsurance to collect from the ambulatory patient, and in most cases must do so with inadequate information as to the status of the Part B deductible, and what effect the \$20 diagnostic deductible will have on the Part B deductible. In our experience this is being handled in a variety of ways, from extension of full credit, to collection of maximum deductibles and coinsurance, with frequent post-adjustments and refunds.

The intermediary performs a bill review function to determine the appropriateness of the services in terms of program benefits, and the adequacy of the data provided. The following general procedural steps are then performed:

1. A wire query (or queries) is transmitted to SSA in Baltimore through the BCA communications system, to solicit the status of the Part B deductible, since the patient liability and reimbursement to the hospital is dependent on the current status of the deductible. (Note: If the period of service involves the 4th calendar quarter, and any other calendar quarter, separate queries are required because of the "carry-over" provision, whereby charges in the 4th quarter, applicable to the deductible for that calendar year, are also applicable to the deductible for the succeeding calendar year.)

2. The true liability of the patient for deductible and coinsurance is determined, based on the deductible status reported in the SSA query answer, the current charges, and the amount (if any) collected by the provider.

3. Separate arithmetic calculations are made to determine the program liability under Part A, Part B, or both, involving the application of the usual reimbursement rate (which can vary by provider), the deductible, and finally, application of the Medicare 80% reimbursement rate.

4. A separate calculation is also made to determine program liability for the \$20 deductible, which is dependent on the status of the Part B \$50 deductible.

5. The Intermediary must, at present, record a maximum of 22 entries on the form to display the results of the prior calculations. (Note: We are currently working with SSA to reduce administratively the requirement by approximately 50%.)

6. The results of the adjudication are reported to the provider (along with other out-patient and in-patient cases) and interim payments made according to the usual schedule in effect.

7. The receipt and processing of the bills must be recorded for compilation into the monthly workload report supplied to SSA by the intermediaries and carriers.

8. An "Explanation of Benefits" form is prepared for mailing to the beneficiary for each episode. Separate forms are required for Part A only, Part B only, or combined Part A and Part B.

9. The completed bills are batched for transmittal to Baltimore (separate batches by type; i.e. Out-Patient Part A, Part B.)

10. A copy of the bill, and the bill for hospital-based physician services are sent to the Part B carrier.

HOME HEALTH AGENCY SERVICES

Services are covered under Part A or Part B (not both simultaneously but may be coextensive) depending on whether they are post-hospital (Part A) or non-post hospital (Part B). The process of identification of the patient is the same for all episodes of care. In addition to the physician certification of medical necessity, Home Health care requires the delineation of a plan of care by the physician. In the case of post-hospital care, the plan must be initiated within 14 days following a minimum of 3 days of inpatient hospital care (not counting the day of discharge).

The provider initiates the claim by supplying a form of notice of start of care to the Intermediary. A special SSA form is available but need not be used so long as the prescribed information is provided.

The Intermediary, following the usual review for appropriateness and completeness, initiates the following procedural steps:

1. A wire query is transmitted to SSA in Baltimore via the BCA communications system, to solicit the patient's eligibility under Part A and/or Part B, and the current availability of benefits (A and B).

2. Based on the eligibility displayed in the wire response, and the data provided by the agency (prior hospital stay e.g.), a determination is made as to whether the case will be processed as Part A or Part B, and the decision relayed to the agency.

The agency prepares a bill for services at intervals established by mutual agreement. Under Part A there is no deductible, but if the case is applicable to Part B, the agency at this point does not know the precise status of the \$50 deductible, and faces the same collection problem as does the hospital in out-patient cases.

The Intermediary initiates the following billing procedures:

1. If the case is payable wholly under Part A, the bill is reviewed for appropriate charges and completeness. A calculation is made as to program liability, notification and payment prepared for release to the agency, receipt and processing recorded for workload reports, and bills batched and released to SSA.

2. If the case is payable wholly, or partially, under Part B, a wire query is transmitted to SSA in Baltimore to determine the current status of the Part B deductible.

3. Under Part B, a calculation is made to determine the patient liability and program liability, depending on the Part B deductible status. This is followed by notification and payment to the agency, recording of workload data, and batching and release of bills to SSA.

HOSPITAL AND EXTENDED CARE FACILITIES INPATIENT SERVICES

Hospital (including general, psychiatric and tuberculosis) and ECF cases are handled in the same general workflow, with the exception of the prior hospital stay (3 days) and transfer (within 14 days) requirements applicable to ECF. In addition, special rules, applicable to ECF certification, must be recognized.

The provider services are covered under Part A, but, as in the case of outpatient services, the professional component must be recognized and handled separately. The process of identification of the patient is consistent with other types of cases.

The provider initiates the claim by supplying a notice of admission to the Intermediary. A special SSA form is available, but not mandatory. In the case of ECF services, additional information as to prior hospital stay is required.

The Intermediary reviews the notice of admission data, and then follows the general query procedure cited above to determine eligibility and remaining benefits available. In the case of ECF's, in addition to verifying the patient's compliance with the prior hospital stay and transfer requirements, the Intermediary must also make a judgment as to the facility's acceptability for reimbursement as of the transfer date. This involves a rule recently established by SSA, that a facility which applied for certification prior to December 17, 1966 and is certified (effective) prior to February 1, 1967, "is deemed to be certified as of July 1, 1966" for purposes of applying the 14 day transfer rule. If the facility does not meet these requirements, benefits are not payable even if the patient should then transfer to a certified facility which met the requirements.

The provider, following receipt of approval and a statement as to remaining eligibility and deductible status, may supply a bill at intervals or at discharge or exhaustion of benefits. In addition, a "bill" with minimal data, must be supplied at point of discharge where the patient has exhausted benefits while still hospitalized. In the case of an ECF, a "bill" is required every 60 days after exhaustion of benefits, even though the patient may be institutionalized for life. Also, a separate bill is prepared for the professional charge component as described in the outpatient processing.

The Intermediary, having verified the eligibility and remaining benefits, performs a bill review as to appropriateness and completeness, calculates the interim reimbursement, and completes the processing by notifying and paying the provider, recording the statistics for workload reports, and batching and transmitting the paid bills to Baltimore.

The CHAIRMAN. On pages 10 and 11 of your statement you make certain recommendations with respect to the part B deductible. Have you endeavored to ascertain what the costs of these recommendations might be?

Mr. McNERNEY. We haven't got a clear focus on that, Mr. Chairman. A ball park figure would be that it might cost an extra dollar for both the part B voluntary participant and the Government, a dollar each, raising the cost from \$6 to \$8 in total, and it might require a change in the co-pay percentage from the present 80-20 to perhaps something like 75-25 or 70-30. It is somewhere in that area on the basis of what limited information we have been able to accumulate so far.

I think, if I may add, that these are not excessive amounts in terms of the appalling amount of confusion that exists around the present system.

The CHAIRMAN. In 1965 I believe you had an estimate when you testified as to hospital utilization under medicare which was about 40 percent higher than the administration's estimate.

Am I correct according to your recollection of it?

Mr. McNERNEY. We went through several estimates and counter-estimates as that bill was emerging and I think when we got down to the wire, Mr. Chairman, we were apart by something closer to 13 percent than we were 40 percent.

The CHAIRMAN. You mean with the administration?

Mr. McNERNEY. Yes, and this difference was one that was certainly understandable in terms of the size and complexity of the program, but it came down to that extent.

The CHAIRMAN. You are talking about hospital utilization?

Mr. McNERNEY. Yes.

The CHAIRMAN. Was that with respect to per diem costs, that figure, 13 percent?

Mr. McNERNEY. The per diem difference.

The CHAIRMAN. Let me get my own recollection straightened out here. I thought that when we got to the question of the estimate of hospital utilization under medicare you had an estimate that was about 40 percent higher than the administration's estimate and about 20 percent higher than the estimate that was adopted by the committee.

In other words, we went about half way between you and the administration in that respect. I am not talking about the per diem, but the overall hospital utilization.

How near are the present facts to your estimate, our estimate, or the administration's estimate, do you know?

Mr. McNERNEY. I am not as well informed as I would like to be on this. I would say that what we were talking about at the time was total costs.

The CHAIRMAN. That is right, hospital utilization.

Mr. McNERNEY. Right. It is a product of admissions, stay and per diem, all.

The CHAIRMAN. That is right, not just the per diem.

Mr. McNERNEY. I would repeat that I think the difference came down to a matter of 13 percent which you are getting at in your remarks.

The experience to date I think has shown a slightly larger use than perhaps was estimated by the administration, but again we are a little bit naked in that we don't have access to all the figures that would enable me to say whether it is closer to one or the other.

However, it may be in between.

The CHAIRMAN. You don't know whether it is greater than the percentage increase that we provided in establishing the cost?

Mr. McNERNEY. I don't.

(The following information was received by the committee:)

COMMENTS ON UTILIZATION OF BENEFITS UNDER MEDICARE BY BLUE CROSS ASSOCIATION, CHICAGO, ILL.

On March 6, 1967, chairman Mills requested that Walter J. McNERNEY, president, Blue Cross Association, discuss our estimates of utilization of hospital care by the aged made prior to the start of Medicare in terms of our experience under the program to date. He referred to a "40 per cent difference" between certain of our estimates and those of the Social Security Administration.

Since the hearing, we have had an opportunity to review our earlier comments and try to relate those to the rather limited information that is available so far regarding the actual program. The following comments are submitted.

The 40 per cent difference referred to appears to reflect our estimates that aged persons would use approximately 3.45 days per person per year of inpatient care, at the start of the program, as contrasted with lower estimates submitted by SSA. Our estimate of 3.45 days is included on page 193 of the record of Executive Hearings before the Committee between January 27 and February 16, 1965. Elsewhere in that volume, including on page 348, the SSA estimate for 1967 is stated as 2.37 days.

Actually, it is too early in the experience of Medicare to have access to many of the data that can give quite definitive measures of experience. Therefore, any current evaluation is subject to certain assumptions just as were the original

estimates. For example, data available to the Blue Cross Association at this time are almost exclusively the figures that have resulted in our own administration of a portion of the Part A program. To evaluate our data, therefore, we have to make an assumption. We assume that Blue Cross is providing for payment of hospital care to 17.5 million persons under Medicare, or 92 per cent of the covered Part A population (based on the SSA report that Blue Cross serves 92 per cent of the hospitals participating in Medicare.)

After reviewing all the information available to us, we do not find any reason that would lead us to wish to revise our 1965 estimates downward at this time. If anything, our 1965 estimates may be too low. The actual experience of claims incurred during the first six months of the program and reported through January 1967 suggests that the first year usage of in-patient hospital care will be in the range of 3.9 days per person per year.

Since final settlement under the SSA formula has not been made with a single provider in the United States, because of delays in providing to us the necessary instructions and data, it is impossible even to make reasonable estimates on the final cost of care under the actual program at this time. Our only data relate to what has been paid to hospitals under the interim rates negotiated between Blue Cross and the provider. Although these negotiations were based on sophisticated knowledge of actual cost, there have been enough factors introduced into the final SSA formula to make us hesitate to do more than warn against seeking to conclude what the financial experience may really be.

Again, however, we have seen nothing which would lead us to wish to revise downward our estimate of eventual total cost of the program during FY 1967. In the same record to which reference was made earlier, we projected in 1965 an estimated monthly "rate" of \$11.16 for in-patient care, \$0.10 for out-patient diagnostic care, and \$0.05 for home health services, for a total of \$11.31 for these three items. Using the same assumptions as above, and without any adjustments to allow for potential increases in cost that have not already been reflected in changes of the interim allowances, our experience for the first six months shows a monthly cost per participant in the program (for these three elements of care) of \$11.62. The distribution between the three elements of care is approximately \$11.56 for in-patient care, \$0.02 for out-patient care and \$0.04 for home health services. (Incidentally, the insignificant cost for out-patient diagnostic services demonstrates clearly the extent to which this benefit has failed to meet the need of participants, as I commented during my present testimony).

It should be emphasized again that the validity of our assumption on exposure, 92 per cent of the total persons covered, is fundamental in evaluating the current data available. Of course, if Blue Cross serves fewer than 92 per cent of the total the dollar averages will be greater than shown. But, without a clear evaluation of the validity of this exposure, which can be made only by SSA at this time, our comments can be only indicative.

Of course, application of probable increasing trend factors, both in use of care and in costs of care, which we anticipate but have not reflected at all in the above data, can only result in increasing the cost level further. It is difficult to make projections without data as to the actual program, and it is too soon to have adequate data available to us or to SSA on many important points.

Nothing in our experience to summarize, suggests that the program is currently overfinanced. The data over the months ahead will have to be watched carefully, in fact, to evaluate the possibility of under-financing currently.

The CHAIRMAN. What effect will the current campaign for higher wages for nurses and other hospital personnel have on hospital costs in your opinion?

Mr. McNERNEY. To date a fair amount of this has been absorbed. We will all note that the increase of 1966 over 1965 in hospital cost is about 12 percent as opposed to the average of a 7-percent increase per year which has been going on for the past 10 years. In that 12 percent some of the sharp impact of increased salaries and wages for nurses and others has been already absorbed.

I would anticipate that the increase of 1967 over 1966 might be aberrant also, perhaps somewhere between 10, 12, or 13 percent, but I would foresee beyond 1967 a move back toward the more normal growth of say 7 or 8 percent. The move back will be augmented by the fact that you are building on a larger base too, as you know.

The CHAIRMAN. That would be for 1968 compared to 1967?

Mr. McNERNEY. Right. It is hazardous to predict today, but if you would pin me down I would say that.

The CHAIRMAN. Do you anticipate such an increase over the preceding year for several years into the future?

Mr. McNERNEY. Well, let's put it this way.

The CHAIRMAN. For the next 5 years, say.

Mr. McNERNEY. Yes. We cannot continue on forever because if hospital costs go up at 7 percent and wages and earnings go up at 3-plus percent, in some number of years, I haven't yet calculated, 100 percent of the national product would be consumed paying hospitals. Presumably this can't happen, so when you get near that 5-year period of which you speak, Mr. Mills, steps will have to be taken, even if they are artificial steps, to bring these curves closer together. I would hope we could find the answer within our present structure.

The CHAIRMAN. My concern, and my reason for asking this question, is prompted by the fact that I always want to be certain that we are taking in year by year sufficient money to pay these anticipated costs. If we see anything in the picture today that indicates that the tax may not be enough as of now for the next 4 or 5 years, I would want us to make such adjustments as are required to see that the tax is sufficient to pay these costs.

Do you see anything in the operation so far to give any indication?

Mr. McNERNEY. I honestly am not qualified to give a firm actuarial comment on the adequacy of the funds. I do make this general statement, and that is I don't think the public is going to permit a difference of 7 to 8 percent and 3 percent for a protracted period of time because of the inevitable result I just mentioned. I would foresee that planning of capital structure, and more intensive utilization review, and an effort to pull together, pull together the doctor, and the hospital and the allied facilities, into closer working relationships will depress that rise and, however, it happens, will bring the two curves closer together.

All this says to you, sir, I realize, is that the current rise has a limit and therefore any long-range program will ultimately have to face a 3-, 4-, or 5-percent rise, not a 6-, 7-, 8-percent rise.

The CHAIRMAN. You are aware of course, as I am, that the rise in 1966 was about 3 percent more than we initially anticipated for the year 1966.

Mr. McNERNEY. Yes.

The CHAIRMAN. Now you estimate that the rise will be 10, 11, 12 or 13 percent in 1967 over 1966, which again presents a higher rise for 1967 over 1966 than we initially thought would be the case. Of course, this not only affects the medical care program, but it also affects your Blue Cross premiums I assume.

Mr. McNERNEY. Yes, it does.

The CHAIRMAN. What has been the situation there? Have they had to increase your premiums as a result of the experience in 1966 over 1965?

Mr. McNERNEY. Premiums are a function of costs and use rates. Actually we have experienced in Blue Cross, separated from the aged complementary contracts—I am talking now of those contracts for citizens less than 65—a lesser admission rate and a reduction in the length of stay, the sum total of which is lower utilization of patient days per thousand of some 13.4-percent. Specifically, I am talking about the third quarter of 1966 as opposed to the third quarter of 1965. A look at the full year may change that. However, we will have to incorporate in our rates the cost factors in the long run that we have discussed, and it has been cushioned by this use reduction, perhaps temporarily.

The CHAIRMAN. Then we should go into the matter of whether or not these developments require any change in our own methods.

Mr. McNERNEY. I would urge that, but I would hesitate to be an expert in the area.

The CHAIRMAN. I am very much interested in the statement you made on page 13 with respect to the coverage within the program of disability beneficiaries and the differences that you point out between the situation involving the disabled and the aged and even within the area of the disabled.

Does your study show that costs of covering the disabled individual are higher than they are on the average with respect to people over 65?

Mr. McNERNEY. Over 65 did you say?

The CHAIRMAN. Yes, sir.

Mr. McNERNEY. I don't know the answer to that. First of all, one of the reasons that the disabled are a problem is that most of us in the private sector haven't got many of them covered so our experience is not too credible and I can't really comment on that although I think from what little I know, having read the Social Security Administration's report on this, that this would vary between the younger and older disabled with the experience of the older disabled under 65 more closely paralleling that of the aged citizens and the long term costs for the younger people perhaps higher, but that is an impression only.

The CHAIRMAN. Is there any source that we might go to to try to find out the answer to the question I propounded to you?

Mr. McNERNEY. There is a footnote on the bottom of page 13, sir, that I think will lead you at least into the area, yes.

The CHAIRMAN. Is this the research report No. 6 that you are referring to?

Mr. McNERNEY. Yes.

The CHAIRMAN. Just a question or so more.

Would it be possible for you to be back at 2 o'clock so that other members of the committee may interrogate you?

Mr. McNERNEY. Yes, it would.

The CHAIRMAN. I am interested in your suggestion at the bottom of page 12, this sec. 164. What you are talking about there is the section that deals with section 1812(c) that relates to those 65 years of age or older who are in some type of a State institution?

Mr. McNERNEY. Yes, sir.

The CHAIRMAN. You suggest that we eliminate that whole thing. Wouldn't the Government just be picking up the first 90 days of care after these people in these institutions reach the age of 65?

Mr. McNERNEY. Yes, sir.

The CHAIRMAN. Why should we do that? I am not arguing with you. I just want to know your thinking as to why we should.

Mr. McNERNEY. I think having gone as far as you have in this particular part 4, title I, that you might as well go all the way. I don't think there would be a major cost involved and you are left with the inevitable discriminations among people who are in very similar situations.

The CHAIRMAN. Also remember now if we take in the disabled as well as those over 65 we would be picking up the disabled within the institutions, would we not, as well as those over 65?

Mr. McNERNEY. May I consult for just one moment here?

The CHAIRMAN. I would like to know. Yes, if you have somebody that can help you with the answer.

Mr. McNERNEY. It wouldn't cover custodial care, which most of them are.

The CHAIRMAN. No, it wouldn't cover that.

Mr. McNERNEY. But you are right; it would cover the other.

The CHAIRMAN. I just wanted to know why we needed to go further.

Mr. McNERNEY. It is primarily an administrative simplicity that would cut down on some difficult decisions and it seems to me if custodial care isn't involved it would avoid a very difficult type decision.

The CHAIRMAN. What procedures have you and other intermediaries set up to reach agreement with hospitals on what the hospital charge should be and what the hospital should be paid? Do you have any procedures that you have established to work out those problems? The hospital thinks your decision is wrong. You think the hospital's charge is excessive.

What is the procedure to reach an agreement?

Mr. McNERNEY. If we think, upon examination, that something has been, let's say first of all, improperly included in costs we would bring that to the attention of the hospital and if there were disagreement on this, and I would say right off the bat that 99-plus percent of these would be solvable on the basis of a conversation—there would be very little problem in this regard, but if there were, this would then be resolved by the intermediary through the audit process in accordance with the regulations and definitions issued by the Secretary through his hierarchy.

In terms of the proper use of the hospital, that is to say, not a fact of whether this is a benefit or not, but whether this is judicious, effective use, as things stand now if the physician testifies to the fact that this care is needed there is very little we can do. We can comment. We can offer our opinion, but we have no final say in that situation.

The CHAIRMAN. Mr. McNerney, we probably should adjourn until 2 o'clock if you will be back with us then.

Mr. McNERNEY. Thank you. I will be back.

(Whereupon, at 12:21 p.m., the committee adjourned to reconvene at 2 p.m., the same day.)

AFTER RECESS

(The committee reconvened at 2 p.m., Hon. Wilbur D. Mills, chairman of the committee, presiding.)

The CHAIRMAN. The committee will please be in order.

Mr. McNerney, on page 12 again in your prepared statement with respect to section 131, part 3, "Certification," I notice that you state, "We hope that recertification would not be required by regulation prior to the 20th day."

Why do you recommend that recertification not be required before the 20th day?

STATEMENT OF WALTER J. McNERNEY, PRESIDENT, BLUE CROSS ASSOCIATION—Resumed

Mr. McNERNEY. Well, the average length of stay for the aged, as you know, is approximately twice that for the general population and it seems to me that if you have to choose a period where a case is likely to become excessive in terms of stay, you move beyond the average stay some point and to me that comes about the 20th or 21st day.

For example, the average stay for all age groups would be about 7 or 8 days and you find a lot of recertification in our programs about the 14th day.

Similarly, if this length of stay is on the average of the aged about 14, 15 days, it seems to me this (20th day) is a suitable checkpoint.

It is an administrative task to do this well and I think it becomes, therefore, important to choose the most judicious point to undertake it.

Then I would check again at some subsequent point beyond that.

The CHAIRMAN. Does this relate to the individual user of the hospital? Is that what you are trying to get to?

Mr. McNERNEY. Yes.

The CHAIRMAN. I see.

What difficulty is experienced under the present regulation?

Mr. McNERNEY. Well, the prime difficulty has been with the initial certification. The physicians have taken the point of view that they would not admit a patient to a hospital unless it were needed and therefore to sign a special statement to that effect was gratuitous.

The CHAIRMAN. I can understand that point of view.

Now what problem do the hospitals have concerning it?

Mr. McNERNEY. Well, the problem from the hospital point of view is getting the doctor to do it. If he does not do it, it makes it difficult to get paid. On the outpatient it was even worse, the practice is for the doctor often to telephone in the admission and then the patient was taken care of.

The CHAIRMAN. On this original certification, is there any difficulty at present being experienced by the hospitals with respect to other aspects of the certification, recertification, or anything of that sort?

Mr. McNERNEY. On the certification or recertification, I would say it was primarily the initial.

The CHAIRMAN. The initial?

Mr. McNERNEY. Right.

The CHAIRMAN. That is what I wanted to find out.

How much cost readjustment have you had to make to bring payments on estimated costs up to actual costs? I am talking about our program, not other programs that you may operate, but this program?

Mr. McNERNEY. You mean what is the difference between our interim payment and our final payment?

The CHAIRMAN. Yes.

Mr. McNERNEY. I don't know yet because the charge information has not been available.

The CHAIRMAN. Pardon me. This is what I am getting at. Do you make the payment on the basis of the estimated cost?

Mr. McNERNEY. Yes.

The CHAIRMAN. And then you make a readjustment to cover the actual cost?

Mr. McNERNEY. Yes.

The CHAIRMAN. Have you had experience now with respect to that?

Mr. McNERNEY. No. The charge data have not been available to make that final determination under RCC.

The CHAIRMAN. I hoped you had some experience with this, because I wanted to ask you how many readjustments are due to changes in the elements of reasonable cost in the reimbursement formula but you don't know.

Mr. McNERNEY. I don't know, although there is an estimate that the difference between what RCC will produce and what an average per diem reimbursement would have is something in the order of 8 percent but that is only speculative.

The CHAIRMAN. I see. You are aware of the so-called Gorham report?

Mr. McNERNEY. Yes.

The CHAIRMAN. That criticizes the hospital insurance reimbursement guidelines in one part with which you are familiar. It has not provided hospitals an incentive to be efficient.

In your opinion, is this a fair criticism or not?

Mr. McNERNEY. I think that that is a difficult question. Let me answer it this way: I think we have got to find some way of getting more incentive for efficiency into the hospital. My own view is that the reimbursement formula does not hold much hope itself for that and you are going to better find that through utilization review, areawide planning and standards for institutional participation.

The CHAIRMAN. He makes two suggestions. Let me refresh your recollection.

One of them has to do with cost-plus-incentive-fee approach in which the institution's demonstrated efficiency would determine the amount of allowable growth factor.

The second one is a fixed-price approach in which the institution prices its services in advance on gains or losses depending on its ability to control cost.

In either case, retail standards of service would have to be specified.

Mr. McNERNEY. That is precisely what I was talking about and that last statement you made is a difficult one.

For example, you can take a group of hospitals, say between 50 and 100 beds, none with teaching program, all rural, so that they were homogeneous. Figure out what their costs were, array in a normal

distribution curve, select some level on that curve and say we will offer you that.

Those who were below it could keep the difference, those above it would have to come down ultimately. The real problem is, what is to prevent the administrator from artificially depressing his costs so that he ends up with a different product that is a lesser quality of care, and that is where the economists, who explored this, run aground.

It is extremely difficult through specification to hold the product constant. The real danger is that if you put a set offering price out in an effort to make an overage, the hospital will give less than optimal care.

Now, no matter how you slice this thing you are in trouble, so my view is that you come back ultimately to putting your strength on capital structure formation and utilization review where the qualitative aspect is adequately protected, but that is a personal point of view.

The CHAIRMAN. Well, let me ask, Mr. McNerney, have we had enough experience actually to know whether we should be concerned about adequate incentive to be efficient in this connection?

Mr. McNERNEY. I think you should be concerned right now and two of the things I said I would simply underscore. One, funded depreciation is a very complicated subject. I would hope that you would join with other elements of the government in designing a bill that would be suitable for all age groups and adapted by all States rather than coming in through this one facet.

As far as the other is concerned, utilization review, I would hope that you would encourage HEW to give the private carriers and intermediaries as much encouragement as possible to explore this area and implement thorough programs of evaluation, helping the hospitals set these review mechanisms up, providing data for their operation, and in every sense watching the care that takes place.

SSA has done a lot in this direction, I hope together we can do more. As things stand now, if a physician says that that care is needed, in the last analysis the intermediary or the carrier has no authority to change the situation. That might deserve a look.

The CHAIRMAN. As you say, you have developed programs that you sell to individuals who have the medicare program to supplement it.

Does this Blue Cross protection provide for payment of deductibles or not?

Mr. McNERNEY. Yes.

The CHAIRMAN. It does. Give me again the figure or the number of people who are covered under the medicare program that you cover for deductibles through additional insurance.

Mr. McNERNEY. We had 5.6 million before the program began. We have about 4.8 million on complementary coverage now which is some 87 percent of the pre-Medicare figures.

Most of these have coverage to fill the deductibles on the institutional benefits. I don't know the precise percentage but I can send you that in a separate statement. A vast majority.

The CHAIRMAN. Mr. Byrnes.

Mr. BYRNES. I want to express to you, Mr. McNerney, our appreciation for your testimony. The information, I think, is very valuable to us.

I inquired of the previous witness, Mr. Pettengill, about what they have been able to do in meeting the problem of the time gap between claims and payments.

What is the situation in those areas that you are administering concerning the gap between filing the claim and the actual disbursement?

Mr. McNERNEY. Well, our current experience is I should judge on inpatient something like a turnaround time of 10 days and for outpatient maybe 14 to 16 days, something of that sort.

Mr. BYRNES. You are down to a 2-week period now?

Mr. McNERNEY. Yes.

Mr. BYRNES. You heard Mr. Pettengill?

Mr. McNERNEY. Yes.

Mr. BYRNES. So you are on the same schedule then, concerning time of payment?

Mr. McNERNEY. Yes.

Mr. BYRNES. That is a shorter time than you were experiencing a few months ago, isn't it?

Mr. McNERNEY. The part A benefits, institutional, they have never been in bad shape really. The problem has been largely under the part B benefits and we have relatively less traffic in that area.

Mr. BYRNES. I have heard complaints and I have read in the paper about hospitals being in financial trouble due to payment lags. Is it your view that this is an exceptional hospital?

Mr. McNERNEY. It does by individual hospital, Mr. Byrnes. Let me tell you what I think the problem is. That is to say, some have a larger problem than others but, in our view, the problem of slow payment that the hospital complains about is due partly to payment under title XIX, as well as to XVIII, despite the fact that there is a current financing provision and an emergency provision worked out by SSA to solve this problem under XVIII.

Many hospitals are very slow in preparing the bills. Beyond a certain point an emergency payment does not solve the whole problem.

There was time early in the game when the intermediaries got such a surge of volume that they were part of the problem. I don't think that is the case any longer.

The amount of paperwork, the amount of excessive detail that it takes to prepare a bill has overwhelmed hospitals, they have not prepared the claim.

Finally, we come to the fact that under the uncovered services, the deductible for example. Not knowing what it is hospitals have not even rendered a bill for the patient, particularly an outpatient.

This has resulted in a loss of income so in fact their working capital has been jeopardized.

Mr. BYRNES. Do you know anything about the delay they are experiencing in presenting their claims?

Mr. McNERNEY. Well, we do have some figures reflecting a study done in December which I would like to submit to you on the subject of the timelag between date of discharge and when the claim was given the intermediary.

Mr. BYRNES. That is what I have in mind.

Mr. McNERNEY. For inpatient care it was something like 2 weeks and for outpatient, twice that. Now that is a lot of working capital tied up, as you know.

Mr. BYRNES. You have a lapse of a month, then, between the time the person was discharged and the time that they finally get a check back.

Mr. McNERNEY. On inpatient; a greater time on outpatient.
(The following information was received by the committee:)

MEDICARE ELAPSED-TIME STUDY AS OF DECEMBER 22, 1966, BY BLUE CROSS
ASSOCIATION, CHICAGO, ILL.

Table I contains a summary of the results of a one-day survey conducted by the Blue Cross Association for elapsed times of various Medicare processing functions.

This study was for bills received on December 22, 1966, to record from date of discharge to date forwarded by hospital. The Plan processing times were taken from bills paid on that date. Seventy of the seventy-four Plans responded, although some did not receive bills or pay bills for all three benefits on that date. Therefore, lines one, two and three will not equal the total of line four.

The size categories in the report are based on the estimated number of aged persons in the Plan areas. Although, this was only a one-day study, and to some extent was affected by the holiday season, we believe it has validity in pointing up the time problems. For regular Blue Cross in-patient cases, the hospital processing time is about half of that for Medicare. The Plan processing time for their own cases is about the same as for Medicare. For out-patient cases Medicare processing times are even further out of line in comparison with regular Blue Cross.

TABLE I.—*Medicare elapsed time study as of Dec. 22, 1966*

	Plans with 300,000 and over	Plans with 150,000 to 300,000	Plans with 75,000 to 150,000	Plans with under 75,000	All plans
Inpatient:					
1. Date of discharge to date forwarded by hospital.....	25.7	20.0	19.0	19.3	21.1
2. Date forwarded to date approved....	10.6	8.8	8.0	7.0	8.5
3. Date approved to date paid.....	7.5	8.2	9.9	6.6	8.0
4. Total, discharge to date paid....	43.4	37.0	36.5	32.9	38.1
Outpatient:					
1. Date of visit to date forwarded by hospital.....	44.9	42.3	44.6	37.7	43.5
2. Date forwarded to date approved....	30.7	27.8	19.5	11.9	22.6
3. Date approved to date paid.....	6.4	10.6	12.6	7.5	9.2
4. Total, date of visit to date paid.....	79.5	80.0	75.6	57.4	74.9
Home health:					
1. Date of discharge to date forwarded by agency.....	31.3	24.4	32.6	19.0	27.3
2. Date forwarded to date approved....	15.8	19.4	17.5	9.3	15.3
3. Date approved to date paid.....	8.9	8.1	7.9	7.6	8.2
4. Total, discharge to date paid....	58.3	51.1	57.9	37.5	52.5

Mr. BYRNES. The form report of March 2 seems to differ from your statement to the chairman concerning the increase in hospital charges.

They indicated that 1966 hospital daily charges went up 16.5 percent as against a rise of about 6 percent a year between 1960 and 1965. — I think you said 12 percent.

Is there a reason for that?

Mr. McNERNEY. Mr. Byrnes, I think HEW is talking about hospital room rates. I was talking about total per diem costs.

The 16-plus percent pertains to room and board charges. This is the normal name given to it. I was talking about total per diem hospital costs. I think both figures are correct, if I could put it that way.

The 12 percent that I mentioned is accurate as it pertains to per diem hospital costs; 16.5 percent is accurate in terms of room and board charges.

Mr. BYRNES. It seems to me there are two things that differ here. You say one is room and board charges. That does not include the other hospital services?

Mr. McNERNEY. That is right, not the ancillary services; and it is a charge figure, not a cost figure.

What I am talking about is cost of both room and board and ancillaries.

Mr. BYRNES. The charge also includes what the hospital is charging. In using the word "cost" you refer to what it costs them to perform the service.

Mr. McNERNEY. Right.

Mr. BYRNES. That is a different situation, too?

Mr. McNERNEY. Right.

Mr. BYRNES. Well, can you draw the assumption here that costs last year went up less than the charges went up?

Mr. McNERNEY. Yes, based on those two sets of figures alone.

Mr. BYRNES. In other words, they are charging a larger differential than they were before?

Mr. McNERNEY. That is one presumption.

Mr. BYRNES. Over and above the actual cost to the hospital rendering the service?

Mr. McNERNEY. We are talking just about room and board. What happened to the ancillaries under those conditions, sir, we don't know from these figures, but on the basis of that little information one would assume that happened.

Mr. BYRNES. On its group plans in various communities Blue Cross has in the past—and I assume it still does—obtained from the hospital a formula on which they will be reimbursed. In a sense you have really bargained with the hospitals.

Mr. McNERNEY. Right.

Mr. BYRNES. Since the hospital costs of the over 65 are provided, there is no longer any need to transfer some of the costs attributable to the elderly to those under 65. Have you found that this has reduced the costs that you are paying for your under 65 patients?

Mr. McNERNEY. We are just now beginning to get experience that allows me to answer that. I think I have already pointed out that our utilization seems lower after—

Mr. BYRNES. That is utilization. I am thinking now of the basic charge of the hospital for your under 65 group that you will pay under the formula obtained.

Mr. McNERNEY. I mentioned the other because we always multiply that times the cost in getting our rates as you know, but in talking about the cost to the hospital, not having made these final reconciliations, I am in a very poor position to say exactly what these differences are going to be.

On the one hand, we will be dealing with people that have a shorter stay and we will be paying them on an average per diem. That has certain implications but the real trick is what the RCC formula does and how it causes the hospital to react to that formula.

If it gives the hospital less money than it has been getting or that it figures it should get for the aged people, it may raise the prices

or even negotiate a higher per diem cost for the under 65, but we have not gotten enough experience under this to have me answer you. I am sorry that I can't.

Mr. BYRNES. You recall, though, the rationale advanced in 1955 for the RCC formula that by taking care of those over 65 we would thus remove them as an element in servicing the general population.

One of the arguments made was that this would make it possible to have a lower cost for those under 65.

Mr. McNERNEY. If we come back to that, that is the impact on our rate rather than per diem cost. We have some evidence that our rate periods are holding longer than they would have if the program had not been initiated.

In other words, in some of our States the rate is holding and that would seem to indicate that the lower utilization, particularly, being the factor resulting from the program, has been helpful to the younger population.

Mr. BYRNES. Thank you.

Mr. ULLMAN (presiding). The gentleman from Massachusetts.

Mr. BURKE. On the simplification problem, do you think it is possible for the social security to set up a more simple form of identification of the recipients; say, similar to the type that the credit card system has, a nameplate and a social security number, something of that nature, that could eradicate a lot of these mistakes that are made in spelling and mistakes in social security numbers that causes these delays?

Do you think that that is a possible thing to do?

Mr. McNERNEY. I think that is a possibility. I think maybe another possibility is this: First of all, let me say that in inquiring about eligibility we have a very good turnaround time between Blue Cross and social security in 93 percent of the cases.

The problem comes down to about 7 percent of the cases and among those 7 percent about a total of 1 percent are the real hard core problems.

In addition to what you say, one possibility is that Social Security, that has the machine capacity, could possibly divorce this program somewhat from some of the other programs in terms of programing and administration, because the turnaround time for cash benefits or disability eligibility can be much more leisurely processed than can be for health benefits.

Sometimes the attempt to put both in harness is the difficulty, so I think a combination of what you are going toward and that administrative point both would help.

The important thing is to note that the problem really boils down to a large problem with a new number of cases.

Mr. BURKE. Thank you.

Mr. ULLMAN. Mr. McNerney, are you personally familiar with the situation in Oregon with respect to the part A program that Blue Cross is administering?

Mr. McNERNEY. Generally speaking; yes.

Mr. ULLMAN. I am quite concerned about some of the areas where agreements have not been entered into between the doctors and the hospital where they are being deprived of part A benefits.

I won't ask you to report here but will you personally supply me with a report of those communities and what the problem is?

Mr. McNERNEY. I would be delighted to. Can you pinpoint the problem a little more precisely? I heard you this morning talk about blackout areas. I am not quite sure what we are driving at here.

Mr. ULLMAN. Well, the city of Lakeview in my district is a good example. Would you look into that?

Mr. McNERNEY. I would be glad to.

Mr. ULLMAN. They don't have the medicare benefits evidently, because of a failure in agreement. I think there are some other communities and I would appreciate a report.

Has there been much of this around the country?

Mr. McNERNEY. Not that I am aware of. There have been problems in title VI, as you know, but outside of that, what you are suggesting I am not aware of at all. I would be glad to look into Lakeview and give you a letter on it and any others that we can find out.

Mr. ULLMAN. You favor the actual costs basis or billing that is incorporated in the present system?

Mr. McNERNEY. You are talking about how to pay the hospital?

Mr. ULLMAN. That is right.

Mr. McNERNEY. Under the so-called RCC formula?

Mr. ULLMAN. Yes.

Mr. McNERNEY. Well, I went on record when this subject first came up favoring payment on the basis of average per diem rather than RCC. I still feel the same way. RCC causes a great deal of administrative difficulty in its administration having to keep track of the income ledger as well as the expense ledger and also charges are a very arbitrary way to allocate costs among age groups, that is between older and younger.

They are variously related to cost, and within the room and board charge there is buried a lot of services that do vary between the old and the young that are not highlighted by charges.

I put all of these reasons in a letter to Mr. Ball and this is now being discussed actively between SSA and American Hospital Association hopefully that they will come out with a resolution of it fairly soon.

Mr. ULLMAN. Well, I wonder if we could get a copy of that letter of your thinking with respect to it?

Mr. McNERNEY. I would be glad to supply it.

Mr. ULLMAN. Without objection, we will include that in the record at this point.

Mr. McNERNEY. All right.

(The following information was received by the committee:)

FEBRUARY 9, 1966.

HON. ROBERT M. BALL,
*Commissioner, Social Security Administration,
Department of Health, Education, and Welfare, Washington, D.C.*

DEAR BOB: Under Part A, PL 89-97 a major and far-reaching decision must be made regarding the relative merits of provider payment on the basis of ratio of aged to total charges applied to cost versus average per diem cost. Our purpose in this letter is to set forth some key issues involved for your consideration.

Before proceeding to these issues, I should recognize that it has been the view of your staff in prior conversations that PL 89-97 and the accompanying Reports from The House Ways and Means, and Senate Finance Committees stipulate that reasonable costs incurred by aged patients per se must be reimbursed, whether they are less than or greater than average costs. This interpretation has led to a search for a workable RCC formula.

The Blue Cross Association feels that there are several cogent reasons, even in view of the above interpretation, why SSA should make payment to providers as of July 1, 1966 generally on the basis of average per diem cost, leaving aside, for the sake of this discussion, allied problems such as the problem of defining reimbursable cost.

First, it is highly likely that average per diem cost is a reasonably accurate reflection of use of services by aged persons. It is true that early studies showed that aged patients incurred fewer ancillary charges per diem than younger patients. For example, in August 1965, a representative of Associated Hospital Service of New York reported, on the basis of a study of 53,203 cases paid to hospitals in October 1962, that the overall average charge per day for ancillary services was 6.4 per cent less for patients 65 years old and older than for all patients. Under the assumption that other services (room and board and non-operating expenses) were evenly distributed among patients, it was presumed that when other charges were added to ancillary charges, the percentage difference would be less.

In 1965, in a study of all classes of risk for cases incurred in 1964 and paid through the first quarter of 1965, Michigan Hospital Service reported contract charges per day of \$36.18 for patients 65 and over, and \$39.93 for all patients—a reduction of approximately 9.4 per cent. At the same time, a study based on a 5 per cent sample of Blue Cross cases incurred in 1963 was reported, showing a 5.9 per cent reduction of per diem total charges exclusive of room and board for patients 65 and older (\$13.72 versus \$19.89 for all patients.)

It was fairly commonly understood that averages of this type obscured differences among hospitals. For example, it was demonstrable that some large referral hospitals with a broad scope of services and heavy teaching programs provided more ancillary services per diem to aged patients than other patients. This realization tended to quicken the interest of these institutions in RCC under Part A under the assumption, of course, that other patients would continue to be reimbursed on average per diem cost rates and/or charges.

What was not well understood or known, among other factors, was how services included under the general term *room and board* varied by age. Do the aged use more or less nursing services per patient day, for example? The question is highly pertinent. Some 65–70 per cent of hospital costs are found in room and board, or in the daily service area.

In January, BCA commissioned the Commission for Administrative Services in Hospitals to study nursing time per patient day by age groupings. The results are shown in Exhibit I, attached. In the 14 short term general hospitals studied, those in the 65–90 age group required 10.4 per cent more nursing time than those in the 10–65 age group. It should be noted that this study was based on a measurement of the frequency of procedures performed for patients during the study period. These procedures were translated into minutes and hours through the application of standardized times which did not reflect age differentials. Other qualifications are cited in the Exhibit.

Following the receipt of these results BCA asked CASH for information in greater depth. Both the above study of nursing hours (based on *number* of procedures and the application of standardized times) and charges for ancillaries ignore the *weight* of procedures. What were the actual nursing hours per patient day by age groupings? What were the differential hours by age groupings spent by staff in other departments, such as admitting, business office, cashier, central supply, dietary, emergency room, housekeeping, ICU, laboratory, laundry, medical records, pharmacy, physical therapy, radiology, rehabilitation, recovery room, surgery and technical services? The results received from a Commission member of CASH are shown in Exhibit II.

In regard to actual nursing hours per patient day the aged patients used approximately 37 per cent more than patients under 65. These hours were observed and recorded in 18 short term general hospitals on 65 nursing units. In 8 hospitals, interviews were held with department heads and doctors working in these departments, where pertinent, to ask what their estimates were of personnel time spent on aged versus younger patients. Also, interviewees were asked to state their reasons. On this more subjective basis, it was estimated that in every department aged patients on the average required more attention than younger patients. The weighted average was calculated to be approximately 8 per cent more for aged patients (range 2 to 90 per cent) than younger patients. Other particulars can be seen in Exhibit II.

It would be difficult to translate the above data into financial figures without a certain knowledge of wage rates and the application of frequency weights to

selectively ordered ancillary services. Returning to the first basic point, however, it would appear that if all factors were considered the aged may incur costs similar to the average of all patients. At least fragmentary evidence suggests that the crude measure of frequency expressed in charges of ancillaries favoring aged patients is offset by factors not ordinarily taken into account in an RCC formula. The evidence from Southern California is only fragmentary. It is not representative of the country. It does, however, raise provocative questions which deserve immediate pursuit.

Second, there are practical considerations to take into account. These assume major importance in the absence of certain knowledge of what differential use of services is by age group.

Currently, hospitals have varying charge practices. Some charge an inclusive rate. These would have to shift to a full charge-for-service basic to participate in an RCC formula. Some hospitals vary charges for the same service depending upon accommodations occupied. These would have to standardize charges.

Hospitals vary individually in the manner in which they relate charges to costs by income producing units and in the selection of these units. Presumably, there would have to be some guidelines established in this regard, or else the accidental relationship of charges to costs would affect reimbursement by hospital without necessary reference to the component of age. Put another way, by the simple expedient of varying income producing centers and the charges attributed to them, a hospital could successfully manipulate a given payor, even if large, in the absence of controls.

If the above transitions are to be made and guidelines established, there will have to be effected major changes in the income accounting methods of many hospitals. As a practical matter, there is not time between now and July 1, 1966, (or in the year to follow, for that matter) to make the transition with anything approaching comparability among institutions or areas of the country. To develop charge structures that reflect nursing service differences and other heretofore untapped income centers in a quest for equity, would be out of the question.

Another practical matter is that of administrative cost. Hospitals would have to hire additional billing clerks to implement RCC and intermediaries will have to use significantly more time and staff to audit the income side of hospital ledgers, as well as the expense side. In Michigan the test of RCC in some 40 hospitals demonstrated this point clearly.

If the above observations are valid, it becomes evident that the implementation of RCC would significantly change hospital practices and operations (which is not intended according to the prefatory statements in Section 1801 of PL 89-97), and would cause significant demands on a short labor market. These considerations have to be weighed against the need for SSA to have reasonably good assurance that it is paying an equitable share of costs.

Third, there are some, for want of a better phrase, public policy issues involved.

Experience rated payment methods inevitably have side effects. Will stable working groups fortuitously endowed with favorable experience retaliate in kind, leaving others such as young married couples or those in direct pay status in poorer health, peculiarly vulnerable? Use of services is unrelated to income. Is a payment method based on a concept of artificial categorization socially defensible?

Within PL 89-97 some interesting problems arise. There is speculation that provider payment under Title XIX will be similar to that under Part A. This title will embrace many age groups by 1975. What is the point of age classification under these circumstances? The source of revenue or tax base is hardly a reason to pay by age selectively.

Should working people now shouldering increased taxes be asked to shoulder more costs as the result of the quick application of such a crude measure as RCC? What will be the reaction of these people beyond the possible retaliation cited above?

Even if RCC were to produce a lesser cost for the aged patient today, the situation would probably change in the near future. Alternatives to acute care such as extended care facilities and home care agencies may well tend to focus the general hospital more on acute care for the aged. Special attention to proper use under utilization review and recertification may have a similar result. Many medical science advances are likely to affect the aged disproportionately

(replacement of organs and major blood vessels, cancer chemotherapy, etc.) accelerated in many hospitals by such legislation as the De Bakey Act, and to increase the intensity of hospital use by the aged. The point to be made here is that patient requirements vary over time by age as well as among institutions by age in a given span of time. Does a payor of service attempt to reflect these differences or share with the total community over time what is essentially a community problem?

Without any attempt to dwell on relative inequities under gross RCC or departmental RCC formulas, let us move directly to a few recommendations:

1. Because average per diem payment is the most widely practiced and understood method of cost reimbursement, because it probably reflects reasonably the experience of aged patients, all factors considered, and because of the practicabilities of implementation by July 1, 1966, without undue violence to current hospital operation—SSA should set forth average per diem cost as the principal method with suitable guidelines, making provision for establishment of RCC in a few areas now using it on a non-age specific basis, and build in an evaluation of the merits of each approach.

2. As a refinement, payment of average per diem cost or charges, whichever is lesser, should be established. A charges ceiling on payment would, as much as any method now available, tend to satisfy the intent of Congress that aged patients would not be asked to bear expenses of other age groups.

3. Further hard data should be obtained such as those reported by CASH. Working closely with the American Hospital Association, BCA offers to obtain such data quickly to shed further light on a complex issue.

I should welcome an opportunity to elaborate on our recommendations and the rationale supporting them. Discussions should proceed quickly; a host of decisions hinge on a resolution of this aspect of reimbursement. Quite naturally, providers want to know how they will be paid before signing agreements and intermediaries must tool up carefully for the job of administering the formulas designed.

Sincerely yours,

WALTER J. McNERNEY.

* * *

COMMISSION FOR ADMINISTRATIVE SERVICES IN HOSPITALS,
Los Angeles, Calif., January 24, 1966.

Mr. WALTER J. McNERNEY,
President, Blue Cross Association,
Chicago, Ill.

DEAR MR. McNERNEY: This letter will summarize the results of studies relating nursing time requirements for various patient age groups noted herein.

SUMMARY

The findings represent an analysis of care rendered for 4,942 patient days, based on reports received by 55 medical, surgical, gynecological units in 14 short term general hospitals.

1. The results of the analysis reflect variations in the average nursing time requirements for patients in the age groups listed below. It is significant that the nursing time requirements per patient day increase in a reasonably orderly progression as the age of the patient increases.

Age group	Average nursing time per patient-day		Percent deviation from average	Number of patient- days
	Minutes	Hours		
10 to 20.....	222	3.70	-22	219
21 to 30.....	242	4.03	-4	564
31 to 40.....	240	4.00	-5	798
41 to 50.....	244	4.07	-3	950
51 to 60.....	247	4.12	-2	915
61 to 70.....	253	4.22	+1	801
71 to 80.....	276	4.60	+10	523
81 to 90.....	291	4.85	+15	172
Average total.....	252	4.20	-----	4,942

2. The following table compares the 65 to 90 age group with the 10-65 group, and with the 40-65 age group. The 65-90 age group requires 10.4% increased nursing time in comparison to the 10-65 age group. The 65-90 age group requires 9.2% increased nursing time in comparison to the 40-65 age group.

Age group	Minutes	Hours	Percentage difference	Patient-days
10 to 65.....	244	4.06	-----	3,842
65 to 90.....	269	4.48	+10.4	1,100
40 to 65.....	246	4.10	-----	2,265
65 to 90.....	269	4.48	+9.2	1,100

3. The following table illustrates the percentage distribution of patients by service, i.e. : medical, surgical, gynecological.

[In percent]

Service	Age group	
	10 to 65	65 to 90
Medical.....	47	50
Surgical.....	44	37
Gynecological.....	9	13
Total.....	100	100

4. The following table illustrates the percentage distribution of bed accommodations by age group.

[In percent]

Bed accommodation	Age group	
	10 to 65	65 to 90
Private.....	13	26
Semiprivate.....	69	63
3-bed ward.....	6	5
4-bed ward.....	7	3
Over 4-bed ward.....	5	3
Total.....	100	100

(1) An analysis of the semi-private room accommodation for both age groups indicates that the 65 to 90 age group requires 10.8 percent increased nursing time in comparison to the 10 to 65 age group.

CONDUCT OF THE STUDY

Parameters

- (1) General, short term, nonprofit and proprietary hospitals.
- (2) Medical, Surgical, and Gynecological Nursing Units (excl. I.C.U.).
- (3) Ages of patients from 10 years old to 90 years old.
- (4) Variable diagnosis.
- (5) Variable bed accommodations.
- (6) Nursing time reported includes the following personnel: Head/charge nurses; registered nurses; licensed vocational nurses; nurses aides; orderlies; ward clerks.

General description of study

(1) Each of the nursing units reported patient's age, diagnosis, day of stay and all procedures performed for each patient during the study period, and/or recorded the patient acuity category for each patient during the study period.

The CASH office converted this information to the nursing time requirements per patient day.

Exhibits, illustrating the manner of collecting and analyzing the information, are attached.

Please call or write if we can provide further information or clarification.

Very truly yours,

ROBERT H. EDGE CUMBE,
Executive Vice President.

EXHIBIT I

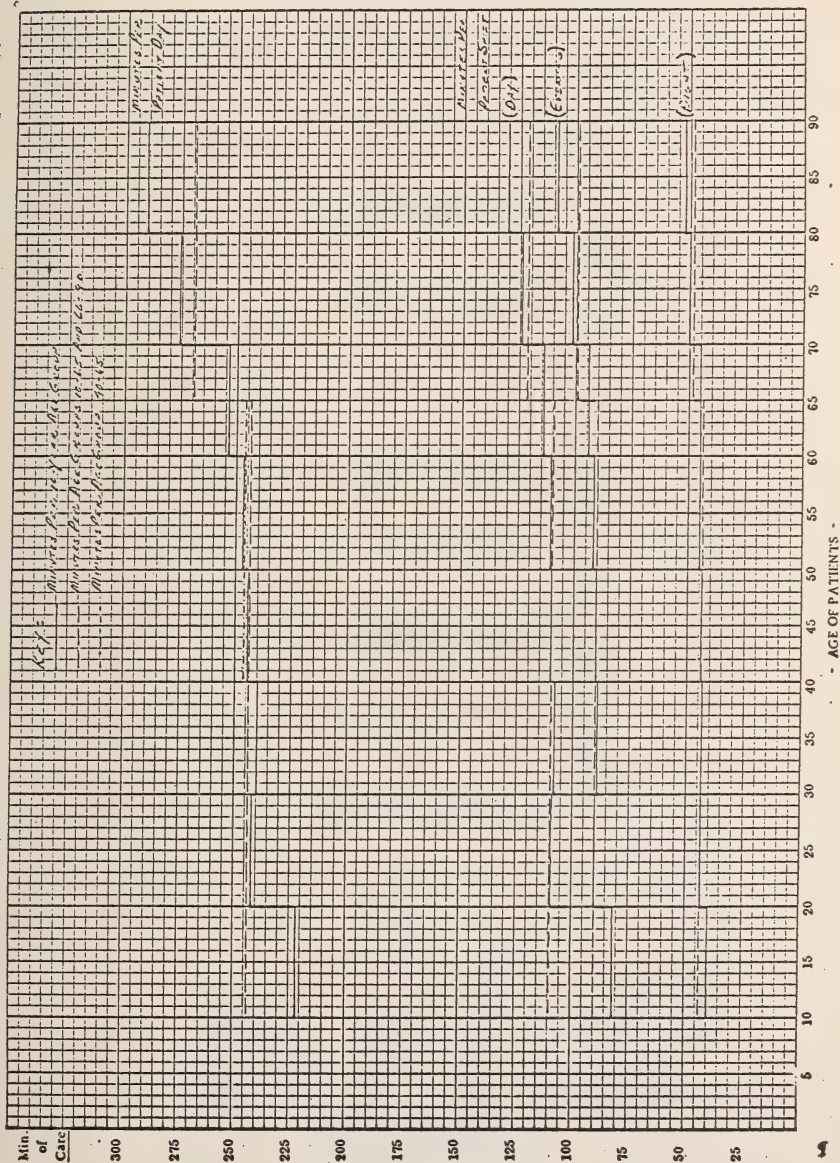


EXHIBIT II.—Commission for Administrative Services in Hospitals, Los Angeles, Calif., age and acuity survey

Hospital	Bed size	11 to 20		21 to 30		31 to 40		41 to 50		51 to 60		61 to 70	
		Patient-days	Minutes per patient	Patient-days	Minutes per patient	Patient-days	Minutes per patient	Patient-days	Minutes per patient	Patient-days	Minutes per patient	Patient-days	Minutes per patient
Donald Sharp	305	5	100	39	131	65	126	75	105	40	104	15	115
Garden Park	95	51	93	47	90	113	96	120	109	67	117	26	127
Santa Monica (November)	273	8	86	10	100	3	105	35	103	36	129	20	103
Anaheim Memorial	71	4	142	15	100	30	125	36	140	20	130	14	147
Hollywood Presbyterian	343	9	122	31	123	45	115	65	113	63	120	99	116
Holy Cross	257	14	108	29	111	38	103	60	110	47	117	38	128
Kaiser-Los Angeles	257	48	87	129	104	107	97	172	98	310	105	283	107
Martin Luther	138	21	97	23	117	89	121	69	133	33	126	33	130
Morningside	136	3	99	41	101	28	108	32	114	24	94	11	98
Santa Ana Community	196	9	114	34	114	30	124	45	123	49	114	24	106
Santa Monica	273	11	104	42	110	50	108	60	115	88	108	111	114
UCLA	305	12	117	70	120	59	124	62	121	70	123	95	124
Valley Presbyterian	162	12	104	35	97	59	93	75	104	47	103	45	99
West Covina	46	9	109	14	100	16	74	32	95	17	96	6	110
Wilmington Community	36	3	145	5	117	6	117	7	99	4	105	1	114
Total number of beds	3,001												
Total patient-days		219		564		798		950		915		801	
Minutes per patient-shift (day)		100		109		108		110		111		114	
Hours per patient-shift (day)		1.67		1.82		1.80		1.83		1.85		1.90	
Hours per patient-day		3.70		4.03		4.00		4.07		4.12		4.22	

EXHIBIT II.—Commission for Administrative Services in Hospitals, Los Angeles, Calif., age and acuity survey—Continued

Hospital	Bed size	71 to 80		81 to 90		Average, 10 to 65		Average, 66 to 90		Number of day shifts	Number of units	Total patient days	Total number patients
		Patient-days	Minutes per patient	Patient-days	Minutes per patient	Patient-days	Minutes per patient	Patient-days	Minutes per patient				
Donald Sharp	305	25	137	9	134	231	115	42	132	9	1	273	78
Garden Park	95	24	119	21	121	411	103	58	122	10	2	469	145
Santa Monica (November)	273	53	129			102	111	63	125	8	2	165	50
Anaheim Memorial	71	16	148	5	144	112	129	28	147	3	1	140	66
Hollywood Presbyterian	343	87	133	38	134	262	117	175	128	3	3	437	204
Holy Cross	257	36	129	14	133	207	112	69	129	3	5	276	129
Kaiser-Los Angeles	357	128	111	13	126	957	101	273	110	4	5	1,230	452
Martin Luther	138	2	128	7	137	251	123	26	132	3	3	277	123
Morningside	136	12	121	8	129	133	104	26	118	3	2	159	74
Santa Ana Community	196	32	136	11	141	179	117	55	130	3	5	234	109
Santa Monica	273	60	119	31	129	306	111	147	119	3	7	453	211
UCLA	305	17	121	5	130	325	122	70	124	3	5	395	185
Valley Presbyterian	162	29	121	10	132	250	100	62	115	3	5	312	146
West Covina	46	1	149			91	94	4	120	3	2	95	45
Wilmington Community	36	1	114			25	113	2	114	1	1	27	27
Total number of beds	3,001												
Total patient-days		523		172		3,842		400		62	55	4,942	2,050
Minutes per patient-shift (day)		124			131		110		121				
Hours per patient-shift (day)		207			218		183		202				
Hours per patient-day		460			465		406		448				

EXHIBIT III

Graph illustrating
Manner of Developing
Information For One Hospital

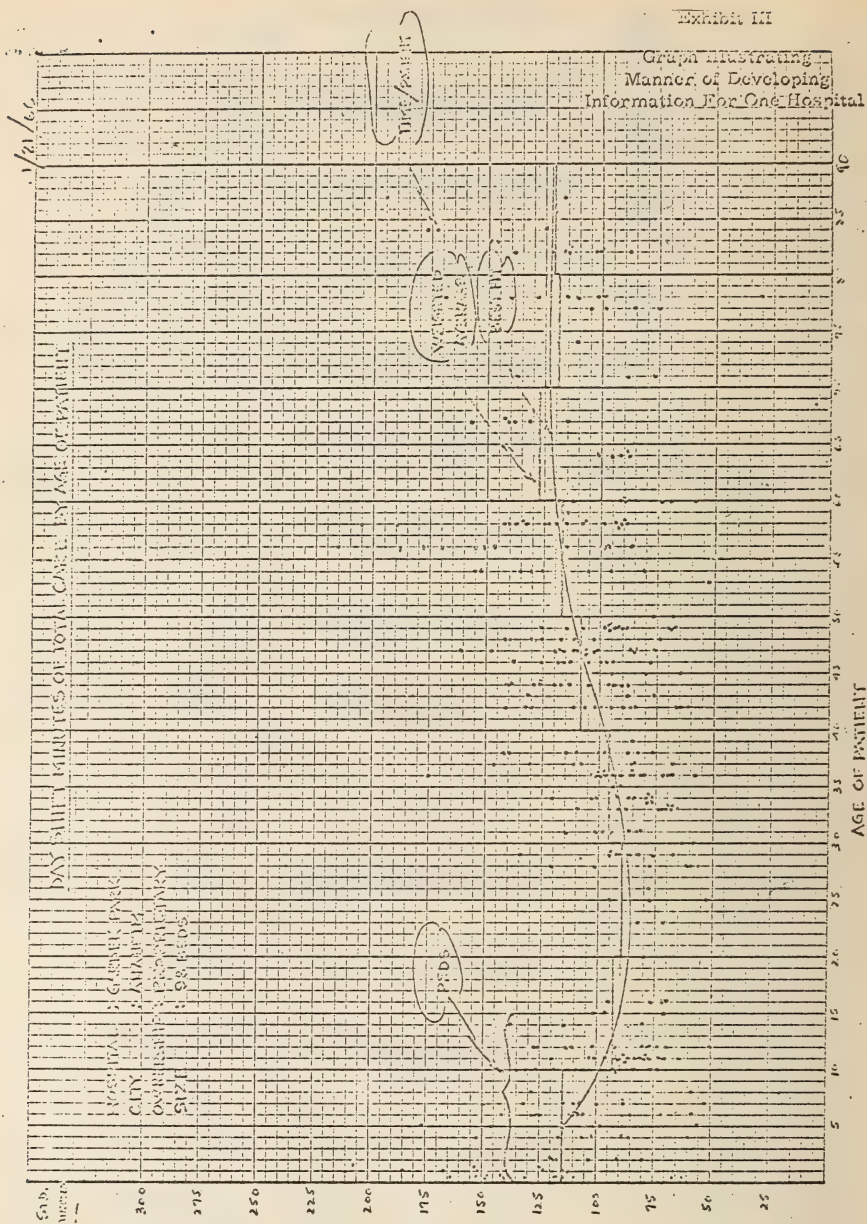


EXHIBIT II

COMMISSION FOR ADMINISTRATIVE SERVICES IN HOSPITALS,
Los Angeles, Calif., February 8, 1966.

Mr. SAMUEL J. TIBBITTS,
Administrator, California Hospital,
Los Angeles, Calif.

DEAR MR. TIBBITTS: This letter will summarize the results of studies concerning departmental labor (hours) requirements for patients under 65 years of age, and patients over 65 years of age.

Summary of nursing time requirements by age groups

The findings represent an analysis of the time requirements for the care rendered for 6,964 patient days, based on reports received by 65 medical, surgical, gynecological units in 18 short-term general hospitals.

1. The results of this analysis reflects variations in the average nursing time requirements for patients in the age groups listed. It is significant that the nursing time requirements per patient day increase as the age of the patient increases. A summary is provided in tabular form on the following page, and graphically in the exhibit section of this report.

Nursing hours per patient-day by age group

Age group	Percent patient-days	Weighted average standard hours per patient-day ¹	Weighted average actual hours per patient-day ²	Percent deviation from weighted average hours per patient-day
10 to 15.....	4.4	3.82	4.46	-8.7
15 to 20.....		3.82	4.46	-8.7
20 to 25.....		3.82	4.46	-8.7
25 to 30.....	11.4	3.82	4.46	-8.7
30 to 35.....		3.82	4.46	-8.7
35 to 40.....		3.82	4.46	-8.7
40 to 45.....	16.1	3.82	4.46	-8.7
45 to 50.....		3.82	4.46	-8.7
50 to 55.....		3.82	4.46	-8.7
55 to 60.....	19.2	3.86	4.51	-7.7
60 to 65.....		3.90	4.56	-6.7
65 to 70.....		3.96	4.63	-5.3
70 to 75.....	18.5	4.06	4.74	-2.9
75 to 80.....		4.25	4.97	+1.7
80 to 85.....		4.63	5.41	+10.8
85 to 90.....	16.2	5.23	6.11	+25.1
Average.....		5.51	6.44	+31.8
		5.64	6.59	+34.9
	3.5	5.66	6.61	+34.5
		4.18	4.89	

¹ Based on measured standard hours per patient-day.

² Based on actual average hours per patient-day (CASH subscribing hospitals for the year 1965).

2. The following table compares the nursing labor (hours) requirements for the two age groups. The 65-90 age group requires 36.6% increased nursing time in comparison to the 10-65 age group in relation to standard measured hours, and also in relation to the actual average hours for CASH subscribing hospitals.

Age group	Weighted average standard hours per patient-day	Percentage difference
10 to 65.....	3.83	+36.6
65 to 90.....	5.23	
	Weighted average actual hours per patient-day	
10 to 65.....	4.48	+36.6
65 to 90.....	6.12	

3. The average *day* of stay during the study was 3.2 for the under 65 age group, and 8.2 for the over 65 age group. The average *length* of stay during the study was 5.6 for the under 65 age group, and 13.6 for the over 65 age group.

4. The following table illustrates the percentage distribution of patients by service, i.e. : medical, surgical, gynecological.

[In percent]

Service	Age group	
	10 to 65	65 to 90
Medical.....	46	50
Surgical.....	46	35
Gynecological.....	8	15
Total.....	100	100

5. The following table illustrates the percentage distribution of bed accommodations by age group.

[In percent]

Bed accommodation	Age group	
	10 to 65	65 to 90
Private.....	15	22
Semiprivate.....	68	65
3-bed ward.....	6	5
4-bed ward.....	8	5
Over 4-bed ward.....	3	3
Total.....	100	100

Summary of estimated time requirements for patients under 65 and patients over 65 in other selected departments and services

The findings represent an analysis of the estimated additional time requirements for patients over 65, based on interviews with department heads and physicians in eight (8) representative hospitals for the departments and services listed in tabular form on the following page.

Summary of estimated labor requirements for age groups under 65, and over 65 for hospital services (in addition to nursing)

Department (includes only departments and services studied)	Estimated percent increased workload for patients over 65	Estimated actual weighted average hours per patient- day based on estimated patient mix				Estimated increased hours per patient-day requirements for patients over 65
		Under 65		Over 65		
Admitting.....	+25.0	(90)	0.220	(10)	0.274	+0.054
Business office.....	+2.0	(80)	.591	(20)	.603	+ .012
Cashier.....	+10.0	(90)	.119	(10)	.131	+ .012
Central service.....	+5.0	(80)	.446	(20)	.468	+ .022
Dietary.....	+3.0	(80)	1.491	(20)	1.536	+ .045
Emergency.....	+15.0	(85)	.171	(15)	.197	+ .026
Housekeeping.....	+3.0	(80)	1.044	(20)	1.075	+ .031
I.C.U.....	+7.0	(60)	.170	(40)	.182	+ .012
Laboratory.....	+10.0	(85)	.798	(15)	.878	+ .080
Laundry or linen.....	+5.0	(80)	.469	(20)	.493	+ .024
Medical records.....	+12.0	(85)	.393	(15)	.440	+ .047
Pharmacy.....	+5.0	(80)	.267	(20)	.281	+ .014
Physical therapy.....	+20.0	(75)	.207	(25)	.248	+ .041
Radiology.....	+30.0	(80)	.302	(20)	.392	+ .091
Rehabilitation.....	+90.0	(60)	.022	(40)	.042	+ .020
Recovery.....	+15.0	(80)	.204	(20)	.234	+ .030
Surgery.....	+10.0	(80)	.912	(20)	1.003	+ .090
Technical services.....	+5.0	(80)	.211	(20)	.221	+ .010
Total (excluding nursing).....			8.037		8.698	+ .661

Summary of estimated labor requirements for age groups under 65, and over 65 for nursing and including other hospital departments and services

Department	Estimated percent increased workload for patients over 65	Estimated actual weighted average hours per patient-day based on estimated patient mix		Estimated actual hours per patient-day difference for patients over 65
		Under 65	Over 65	
Nursing.....	36.6	4.480	6.120	1.640
Other departments (only those recorded above).....	8.2	8.037	8.698	.661
Total.....	18.4	12.517	14.818	2.301

Conduct of the study of nursing service

Parameters:

- (1) General, short term, non-profit and proprietary hospitals.
- (2) Medical, Surgical, and Gynecological Nursing Units (excl. I.C.U.).
- (3) Ages of patients from 10 years old to 90 years old.
- (4) Variable diagnosis.
- (5) Variable bed accommodations.
- (6) Nursing time reported includes the following personnel :
 Head/Charge Nurses.
 Registered Nurses.
 Licensed Vocational Nurses.
 Orderlies.
 Ward Clerks.

General Description of Study:

(1) Each of the nursing units reported patient's age, diagnosis, day of stay and all procedures performed for each patient during the study period, and/or recorded the patient acuity category for each patient during the study period. The CASH office converted this information to the nursing time requirements per patient day. (It should be noted that the time standards for the performance of each nursing procedure were converted from weighted averages for *all* ages of patients to time standards representing the specific time requirements for each five year age group as recorded.)

Conduct of the survey of other departments and services

CASH consultants personally interviewed department heads, including physicians, representing seventeen (17) hospital services in eight (8) representative hospitals.

Hospital:

Beds

California Hospital	304
Bellwood Hospital	93
Memorial Hospital of Long Beach.....	440
Donald N. Sharp Hospital.....	308
Doctors Hospital—San Diego.....	82
Hollywood Presbyterian Hospital.....	343
Garden Park General Hospital.....	98
San Bernardino Community Hospital.....	228

The interviews consisted of attempting to obtain estimates in the following areas:

1. Do patients over 65 years of age require an increased workload?
2. If so, estimate the increased percent.
3. List the reasons for the increase, if any.
4. What is the present estimated ratio of the number of patients under 65 and over 65, in percent?

CASH converted the data to an estimated hours per patient day increase in order to provide a consistent base for comparison.

The primary reasons for the increased workload are listed below:

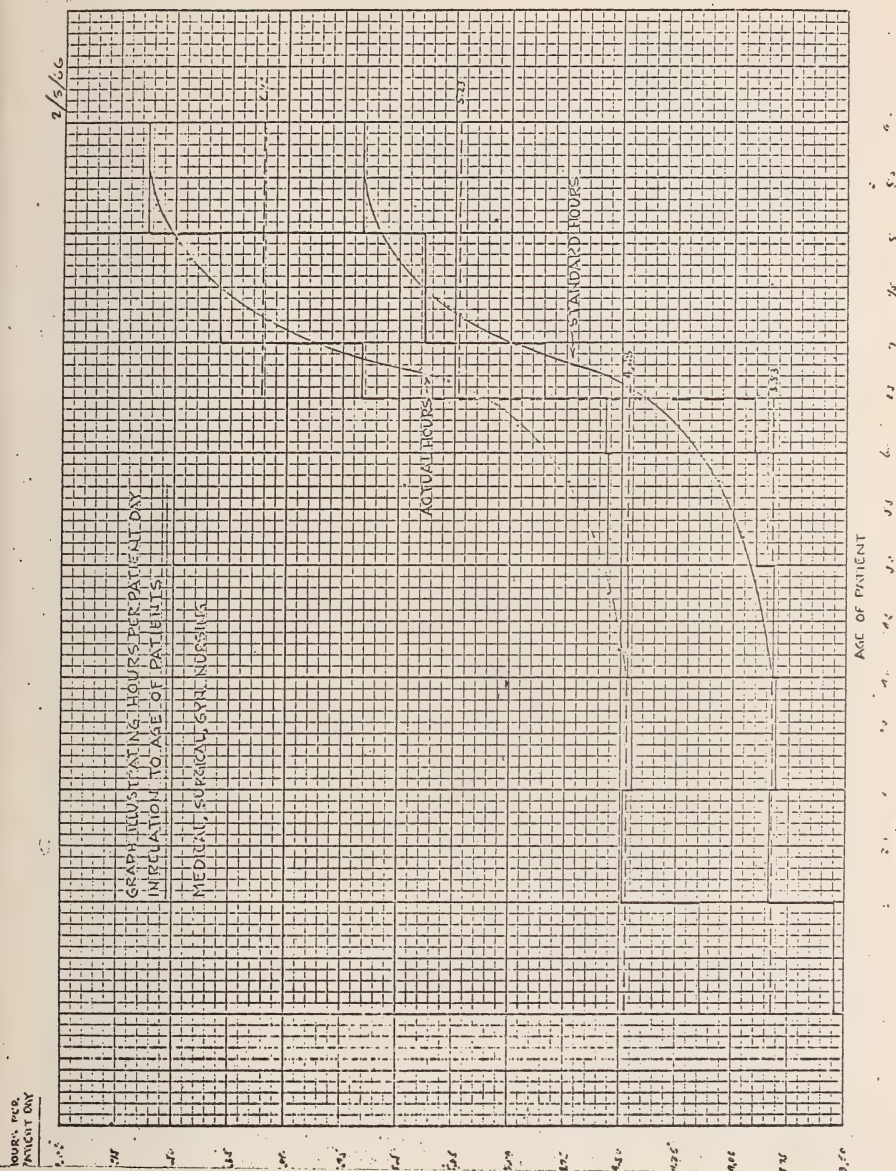
<i>Department</i>	<i>Reasons for increase</i>
Admitting-----	Difficulty in understanding, more self concern. Fewer elective admits. Problems involving an understanding of insurance benefits.
Business Office-----	Financial arrangements and insurance problems.
Cashier-----	Comprehension, financial arrangements.
Central Service-----	Require more supplies, due to complications and longer length of stay.
Dietary-----	More special diets. More returns and exchanges, increased variety and types of food.
Emergency-----	Require more intensive exam, hearing problems. Comprehension problems, increased time for treatments and procedures.
Housekeeping-----	More spills and accidents resulting in special clean up activities.
I. C. U.-----	More attention because of blood pressure.
Laboratory-----	Difficulty in obtaining specimen. Inability to cooperate.
Laundry and Linen Service-----	Higher percentage of incontinency requiring more bed changes.
Medical Records-----	Larger charts due to longer length of stay. Large number of attending diseases associated with primary reason for admission.
Pharmacy-----	Require more medications, more vitamins, laxatives, etc.
Physical Therapy-----	Repair more slowly, less comprehension. Difficulty in giving treatment.
Radiology-----	Difficulty in positioning patient. Difficulty in making tests. Require repeats. Comprehension problem, communication problem.
Rehabilitation-----	Problems of emotional and physical stability. Less physical endurance, treatment. Communication problem.
Recovery Room-----	Blood pressure. Watch longer critical illness. Longer recovery period. More general complications. 10% longer, by medical staff policy.
Surgery-----	Complications in surgery. Generally have more problems, i.e.: handling, transporting, etc.
Technical Services-----	Difficulty in understanding, comprehension. Difficulty in handling the patient.

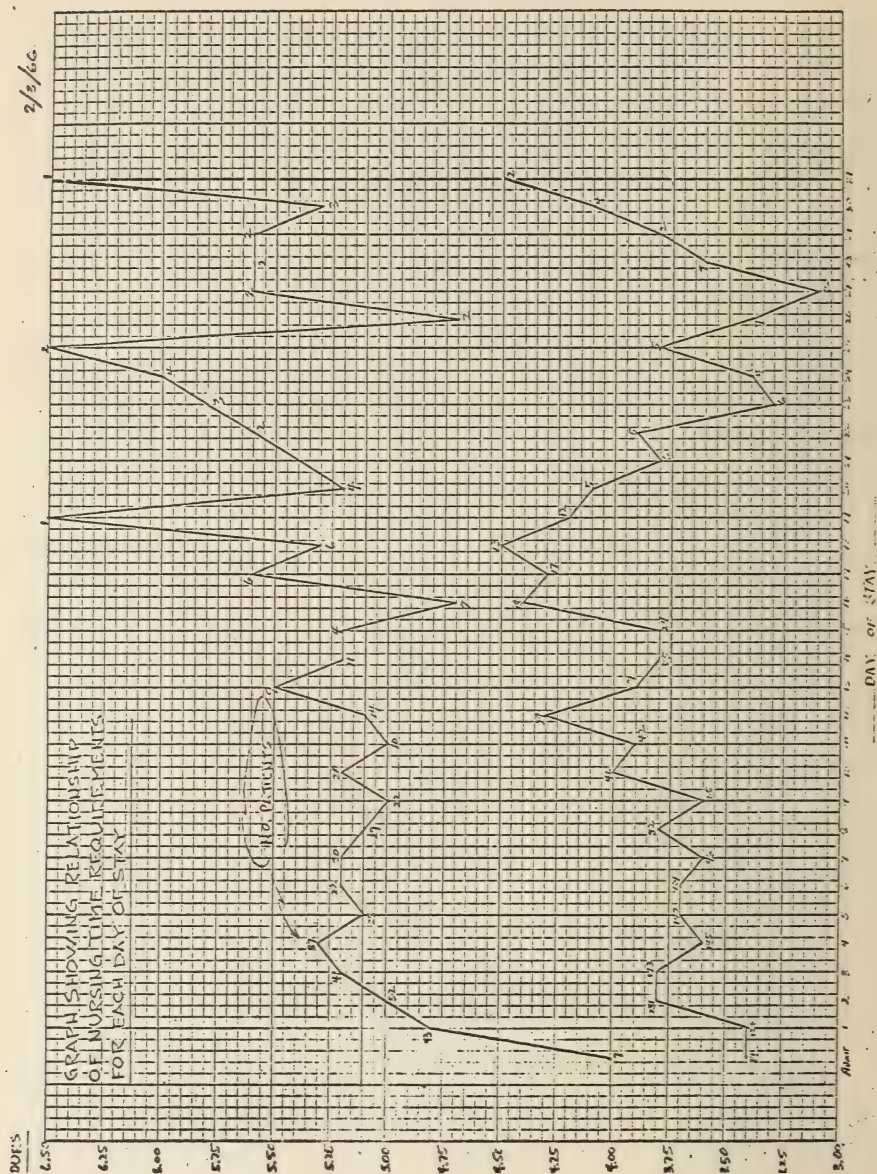
Exhibits, illustrating the manner of collecting and analyzing the information, are attached.

Please call or write if we can provide further information or clarification.

Very truly yours,

ROBERT H. EDGECUMBE,
Executive Vice President.

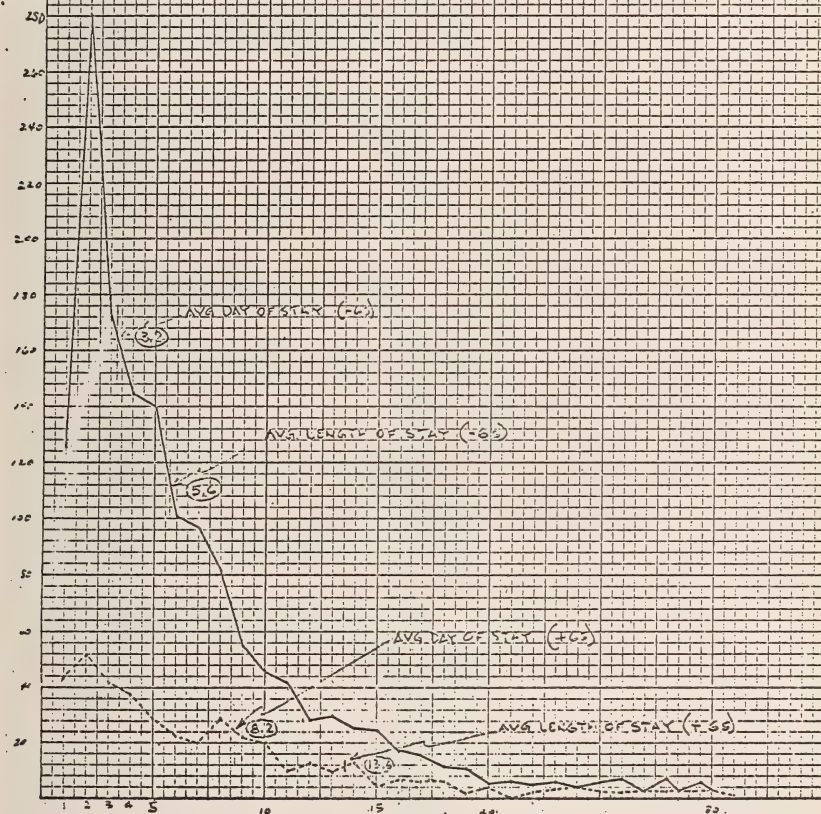




2/5/66

GRAPH ILLUSTRATING NO. PATIENTS BY DAY
OF STAY DURING STUDY PERIOD

No.
PATIENTS



Age and acuity survey

Hospital	Num- ber of beds	Age 11 to 20		Age 21 to 30		Age 31 to 40		Age 41 to 50		Age 51 to 60		Age 61 to 64		Age 65 to 70	
		Patient- days	Hours per patient- day	Patient- days	Hours per patient- day	Patient- days	Hours per patient- day	Patient- days	Hours per patient- day	Patient- days	Hours per patient- day	Patient- days	Hours per patient- day	Patient- days	Hours per patient- day
Donald Sharp	308	5	3.23	39	4.65	65	4.25	75	3.53	40	3.53	7	3.91	8	4.55
Garven Park	98	51	3.37	47	3.29	113	3.58	120	3.96	67	3.94	13	4.39	13	5.56
Santa Monica (Nov.)	273	8	3.29	10	4.50	3	3.81	35	3.61	36	4.65	10	3.47	10	4.30
Anaheim Memorial	71	4	4.85	15	2.54	30	4.24	36	4.76	20	4.41	7	5.01	7	6.21
Hollywood Presbyterian	343	9	3.98	31	4.14	45	3.96	65	3.81	63	4.05	49	3.89	50	4.83
Holy Cross	259	14	3.87	29	3.98	38	3.71	60	3.96	47	4.19	19	4.52	19	5.61
Kaiser, Los Angeles	357	48	3.23	129	3.84	167	3.59	172	3.49	310	3.87	131	3.94	132	4.89
Martin Luther	138	21	3.39	23	4.09	89	4.25	69	4.65	33	4.41	16	4.55	17	5.64
Morningside	136	3	3.31	41	3.39	28	3.63	32	3.83	24	3.17	5	3.28	6	4.07
Santa Ana Community	196	9	4.00	34	3.98	30	4.32	45	4.30	49	3.98	12	3.72	12	4.61
Santa Monica	273	11	3.55	42	3.75	50	3.66	60	3.91	88	3.67	55	3.88	56	4.82
UCLA	325	12	3.65	70	3.73	59	3.86	67	3.77	70	3.81	47	3.87	48	4.79
Valley Presbyterian	162	12	3.54	35	3.41	59	3.16	75	3.53	47	3.52	22	3.86	23	4.19
West Covina	46	9	3.81	14	3.50	16	3.90	32	3.32	17	3.35	3	3.85	3	4.78
Wilmington Community	36	3	3.31	5	3.83	6	3.81	7	3.23	4	3.42	0	0	1	4.63
Total patient-days		219		564		798		950		915		396		405	
Hours per patient-day			3.57		3.83		3.81		3.82		3.90		3.91		4.55

Hospital	Number of beds	Age, 71 to 80		Age, 81 to 90		Average, 10 to 65		Average, 66 to 70		Number of shifts	Number of units	Total patient-days	Total number of patients
		Patient-days	Hours per patient-day	Patient-days	Hours per patient-day	Patient-days	Hours per patient-day	Patient-days	Minutes per patient				
Donald Sharp	308	25	5.90	9	5.48	231	3.93	42	5.61	27	1	273	78
Garden Park	98	24	4.99	21	5.77	411	3.72	58	5.40	30	2	469	175
Santa Monica (Nov.)	273	53	5.78	0	0	102	4.03	63	5.55	24	1	165	80
Anaheim Memorial	71	16	6.24	5	6.10	112	4.54	28	6.21	9	3	140	86
Hollywood Presbyterian	343	87	5.57	38	5.58	202	3.95	175	5.36	9	5	437	204
Holy Cross	259	36	5.76	14	5.94	207	4.01	69	5.76	9	5	276	129
Kaiser—Los Angeles	357	128	5.11	13	5.76	957	3.73	273	5.03	12	8	1,230	452
Kaiser—Los Angeles	138	2	5.55	7	5.94	251	4.31	26	5.71	9	3	277	129
Martin Luther	136	12	5.03	8	5.39	183	3.50	26	4.92	9	2	159	74
Morningside	196	32	5.91	11	6.14	179	4.10	55	5.67	9	5	234	109
Santa Ana Community	273	60	5.02	31	5.46	306	3.76	147	5.04	9	7	453	211
Santa Monica	325	17	4.68	5	5.00	325	3.79	70	4.78	9	5	395	185
UCLA	162	29	5.11	10	5.55	250	3.40	62	4.84	9	5	312	146
Valley Presbyterian	46	1	6.47	0	0	91	3.52	4	5.20	9	2	95	45
West Covina	36	1	6.47	0	0	25	3.53	2	5.55	3	1	27	27
Wilmington Community													
Total patient-days		523	5.39	172	5.66	3,842	3.83	1,100	5.23	186	55	4,942	2,050
Hours per patient-day													

Mr. ULLMAN. Have you any idea why hospital costs have risen at at least twice the increase in the cost of living in the country?

What factors go into it?

Mr. McNERNEY. Hospital costs go up disproportionately to the consumer price index for two major reasons, one of which is that they cannot achieve productivity; namely, there is a minimum opportunity to substitute machines for men so that each new advance in science rather than resulting in a saving in manpower, results in more manpower.

You will notice that the number of personnel per bed as we make progress in medicine goes up rather than down. So medical science has an Alice in Wonderland impact on the services it is rendering.

The second major reason is that more equipment and supplies are required which are susceptible to normal inflationary influences, but it is the first reason which is the most difficult to overcome.

This probably means that there will always be some gap between the consumer price index and the hospital price index. However, our challenge is diminishing.

Mr. SCHNEEBELI. Will the gentleman yield there?

Mr. ULLMAN. Yes.

Mr. SCHNEEBELI. One of them told me that the new \$1.40 hour minimum on February 1 in hospitals caused his hospital an increase of \$5 per day, per room. I think this also is a factor, it not only raises the minimum to \$1.40 but it pushed up the whole range of wages from that point on.

I said, "Can you substantiate this?"

And he said, "I will be glad to give you a brief, detailed breakdown."

He said in his hospital it costs \$5 per day more for room with the effectuation of this \$1.40 an hour minimum wage.

Mr. McNERNEY. May I comment on that, Mr. Chairman?

Mr. ULLMAN. Yes. I would assume that these indicate hospitals generally are paying substandard wages?

Mr. McNERNEY. This relates to this year's cost over last, yours related to the Consumer Price Index.

Mr. ULLMAN. Yes.

Mr. McNERNEY. I think going back to your point, the fact there has been such a precipitous rise this year did reflect that relative to the workers producing most products in the Consumer Price Index hospitals paid less.

I think personally, as many people do, that the employees deserve the raises they recently got.

Mr. ULLMAN. Well, a lot of us feel that way, but the fact is that you are not just maintaining the differential, you are accelerating the differential between the consumer index and the cost of hospital beds and it is accelerating at a continuing, rapid rate; is that not true?

Mr. McNERNEY. Yes, although within the Consumer Price Index as a whole you get the reflection for normal labor increases.

I think the fact that the hospital is beginning to come up to them in large strides has had a short-term transient effect, but over the long pull the problem resides in the two areas that I mentioned.

Mr. ULLMAN. I think there probably always will be a differential, but the problem is to stabilize that differential.

One final question. As I understand your testimony, you would have payments include diagnostic treatment as well as therapeutic with no differential?

Mr. McNERNEY. Yes.

Mr. ULLMAN. Is this, in your judgment, a sound concept of insurance-type protection?

Mr. McNERNEY. Yes. In the first instance, it is often difficult to differentiate between what is diagnostic and what is therapeutic. Often as part of the therapeutic episode you have a diagnostic procedure so you run into all sorts of necessities to make differentiation—in addition in the present bill they are garnished with separate deductibles.

The administrative work becomes excessive.

I think part C does a good job at least in doing away with the differentiation in the benefit periods and the deductible.

We think an added benefit is derived from doing away with the \$50 deductible altogether, increasing the co-pay, if necessary, but the deductible is an awfully difficult thing to keep track of.

Mr. ULLMAN. In a sense, we would be getting into preventive medicine to a degree; is that right?

Mr. McNERNEY. The comments that I have made don't really enlarge the program in terms of preventive benefits.

Mr. ULLMAN. What about the general checkup? Would this include a general checkup?

Mr. McNERNEY. No; that is still excluded under the law, although a diagnosis based on a complaint is covered.

Mr. ULLMAN. Would you not still have a real great difficulty of differentiating between the diagnostic treatment and a general checkup?

Mr. McNERNEY. The answer is "Yes."

Mr. ULLMAN. So you would not be eliminating—

Mr. McNERNEY. Except that the difficulty does not reside in my part, we do what the doctor says in that respect unless there is some good reason to question it, in which case we do. The line has to be drawn by the physician on the case.

Mr. ULLMAN. The gentleman from Pennsylvania.

Mr. SCHNEEBELI. As I stated, I had a conference with three hospital administrators in my district Saturday. Generally, they were very pleased with the help they were getting from the Northeast Pennsylvania Blue Cross Association; they found it very satisfactory.

Mr. McNERNEY. I am delighted to know that.

Mr. SCHNEEBELI. They had some specific suggestions for improvement of the program, on some of the details, and they asked me how best to implement this.

I told them that I thought possibly a resolution which the State Association of Hospital Administrators could send down through the social security office would be the better approach to it because then they can get the overall aspect of so many hospitals in the State of Pennsylvania.

Have you any additional thoughts to the suggestion on how best to implement and coordinate this program?

Mr. McNERNEY. I think that I spelled out in the testimony most of the thoughts that we have had. We have others that probably are

the type of thing, sir, that on an everyday basis we would be working out with SSA and that gets into such small detail that it would burden the committee to talk about it.

A general notion, which I would underscore is that the SSA should rely upon the good judgment and facilities and practices of the hospitals and the intermediaries as much as possible rather than trying to put too much detail and rigidity into the program.

We have a variegated system in this country, many practices have grown up. The trick, as far as we are concerned, is for SSA to say, "Here are our objectives, here is some criteria and we will hold you accountable and then let us run it."

That would speed things up considerably.

Mr. SCHNEEBELI. In that connection, they showed me a couple of invoices for less than a dollar each and they said the mere processing of this would be a costly task and they would hope that this would be unnecessary.

Mr. McNERNEY. Well when you get an outpatient program where the benefit is worth \$4 and it costs that or more to administer it, one has to stop and think about the economic efficiency of the program.

Mr. SCHNEEBELI. Thank you.

Mr. ULLMAN. Mr. Watts.

Mr. WATTS. I don't know if this is a proper question for you or not, but has there been a great deal of difficulty so far over the controversy between the various hospitals and the HEW as to what factors should be considered a part of the cost?

Mr. McNERNEY. If your question is, Has there been controversy, the answer is "Yes."

Mr. WATTS. Well, what, in your opinion, would be the cost if all of the facilities were put on the same cost basis insofar as medicare patients and other patients were concerned? Is there much difference between the average cost of furnishing a room of the same type, and the same type of service, for a medicare patient as there is for a regular patient?

Mr. McNERNEY. This is a subject that I am sure the American Hospital Association—

Mr. WATTS. I am sure they will, too. That is why I want to press the remark. I want to get your remarks as well as theirs.

Mr. McNERNEY. Well, if you ask me, I will give it to you. Within the room and board which is set the same—

Mr. WATTS. Set?

Mr. McNERNEY. It is set the same for all patients varying only with the accommodation, private, semiprivate, or ward, but let us consider semiprivate, as an example. In that charge there are varying amounts of nursing care rendered not reflected by the charge.

I think that the American Hospital Association will get into detail with you that whereas the aged use lesser ancillaries, that is extra services, within the room and board charge, they use more nursing care, so you come out about even.

Mr. WATTS. About even?

Mr. McNERNEY. In other words, even though the aged use less ancillaries, the fact that they use more nursing care and other elements buried within the daily service charge; means that their average experience is about comparable to someone who uses a greater number of ancilliary services but a fewer number of nursing services.

Mr. WATTS. In other words, if I follow you, they come out about the same?

Mr. McNERNEY. Yes and the average per diem formula is much simpler to administer and it is no less equitable.

Mr. WATTS. In other words, it is your opinion, then, that if all of them were put on the same charge basis it would not make a very great difference as far as the expenditures out of social security fund is concerned?

Mr. McNERNEY. I would have to correct that. If you take advantage of the fact that buried within the room and board charges are the main differences that the aged have over the others, then you can get a lesser rate by staying on RCC.

Mr. WATTS. I didn't follow that, sir.

Mr. McNERNEY. Well, it is an advantage to the Government to pay on a RCC basis because it ends up paying less than average per diem overall.

In some hospitals, yes; some, no, but in general, less.

Mr. WATTS. How much difference does it ordinarily make?

Mr. McNERNEY. The estimate is 8 percent but until we reconcile these statements and get our year-end closed and our comparisons made, it is only speculation, sir.

Mr. WATTS. Is it 8 percent overall?

Mr. McNERNEY. Yes, sir.

Mr. WATTS. In other words, that would do away with an awful lot of arguments; make it simpler to administer?

Mr. McNERNEY. The simplicity of administration is without argument, I think. The question of equity is still under some discussion.

Mr. WATTS. There could be no questions of equity, either, if it were settled on that basis?

Mr. McNERNEY. I share that view, but I have not thrilled too many people with that view yet.

Mr. WATTS. Still, on the other hand, is it your opinion that there is a differential of 8 percent?

Mr. McNERNEY. Well, I will tell you the truth. I asked a member of my staff before I sat down here and that is what he told me, and God help him if he is wrong, but I honestly don't know what it is going to be.

Mr. WATTS. I am sure that it varies from hospital to hospital.

Mr. McNERNEY. That is true because in a large teaching institution with an active teaching program the aged, since most of them are referrals having had very complicated conditions and perhaps subsidiary conditions, are apt to cost more on an RCC formula. Therefore, you get the situation in which the teaching hospitals, where the intense case might be, pulling for it the others against it.

Actually, the only true equity would result from breaking all services down and putting charges on each, charging for meals, charging for nursing services, and so forth, so you would know on a quantitative basis what the relative frequencies of use were.

Mr. WATTS. If the amount was made level all the way through, of course, you might increase some of the payments on the medicare patient. But at the same time would that not have the tendency of allowing the average to go down some even if one segment of it was up a little bit?

These hospitals are supposed to operate on a cost basis anyway, aren't they, sir? If you take one category of patients and their cost went up a small percentage, would that not reduce the level of all costs? Did your men take that into consideration when he gave you the 8-percent figures?

Mr. McNERNEY. I don't know.

Mr. WATTS. You see what I am talking about, don't you? In other words, if you have one group of patients under medicare whose costs are allowed to go up a little bit, then that certainly, if a hospital is operating on a cost basis, this ought to have a tendency to lower the cost to the hospital of the other patients.

Mr. McNERNEY. Theoretically, you are right, but let me say that the—

Mr. WATTS. You mean they would find some other way of using it?

Mr. McNERNEY. You took the words out of my mouth.

Actually, you can't blame the average hospital for wanting to do a better job and that motivation is really the strength of our system.

Mr. WATTS. It is tremendously costly to modernize equipment, isn't it?

Mr. McNERNEY. That is right, so the trick is, in my view, not discouraging that motivation but controlling the capital structure so that not all hospitals automatically increase because they now exist.

Mr. WATTS. On what basis does the HEW arrive at the cost? Did they take a certain percent of the regular charge and just say that is the cost for medicare patients or do they make a separate calculation for each hospital?

Mr. McNERNEY. They separately calculate each hospital.

Mr. WATTS. Do they do it yearly?

Mr. McNERNEY. Yes. They pay on an estimated rate through the intermediary more frequently than that, daily, weekly, monthly, but the final reconciliation is on a yearly basis, and it is not a percentage of charges; it is on a cost negotiated in terms of certain contracts.

Mr. WATTS. You have not this yourself, but I am sure it would be available within the records of your organization. Do you know the percentage of difference for the same service as between a person over 65 and a person under 65, and does it ordinarily run below 8 percent? Maybe that is where he got his information; I don't know.

Mr. McNERNEY. Let me say this. If you put it on the frequency of service—

Mr. WATTS. I was talking about average per diem or the average bill for—

Mr. McNERNEY. The program is too new for me to give you an answer other than the opinion expressed. It is just that we have not closed out the first year yet, you see.

Mr. WATTS. Do you think that full utilization is being made of hospitals by people under medicare?

Mr. McNERNEY. I rather think that one of the influences that medical science is going to have is to keep people alive longer and this is going to be the result of more complex diagnostic and therapeutic procedures. This is going to mean, among other things, that the intensity of care for the aged, if anything, is going to increase and you are going to find not only more intensity within the daily room charge of nursing but you are going to find the greater use of ancillary services, as well.

So, I would look for the aged to have a more intense cost experience in the future.

Mr. WATTS. Than the present record shows?

Mr. McNERNEY. Right.

Mr. WATTS. That is all, Mr. Chairman.

The CHAIRMAN. Mr. Battin?

Mr. BATTIN. As I understood, Blue Cross is opposed to any reduction.

Mr. McNERNEY. Generally; yes.

Mr. BATTIN. Just a minute ago you discussed a program of supplemental insurance that took care of the deductible that would cost about \$6.80 a month.

Mr. McNERNEY. Depends on the plan. It could be that.

Mr. BATTIN. Would \$6.80 be an average high or low?

Mr. McNERNEY. For Blue Cross and Blue Shield, it would be an average. Just for Blue Cross it would be maybe \$3.50 of that.

Mr. BATTIN. If you took that statement and looking at both plan A and plan B and took the 20 million people over 65 and eligible that would receive this, it would run something like \$1,017 million. That would have to be somehow raised through taxes.

Mr. McNERNEY. Well, earlier in the day I made mention of the fact that if the \$50 deductible under a new B program that encompassed also the out-patient benefits under A, if that deductible were done away with and the copayment were increased so instead of being 80-20 it were 75-25 or 70-30, then it would probably cost somewhere in the neighborhood of an extra dollar per month per voluntary subscriber under part B, matched by a dollar of the Government.

So, that is our estimate which partly changes your figures by the increase of the copayment.

Mr. BATTIN. No deductible?

Mr. McNERNEY. That would go to zero. The savings would be incalculable because of the amount of administrative work that is now involved in the program which, to me, is not only a cost thing but it is terribly confusing to the aged.

The CHAIRMAN. Any further questions?

If not, Mr. McNERNEY, we certainly appreciate your coming to the committee and helping us with these problems.

Mr. McNERNEY. Thank you for the opportunity.

The CHAIRMAN. Dr. Ackerman and Mr. McCabe.

Dr. Ackerman, you have been with us before. If you would identify yourself in this record, we would appreciate it.

STATEMENTS OF CARL R. ACKERMAN, M.D., CHAIRMAN, BOARD OF DIRECTORS, NATIONAL ASSOCIATION OF BLUE SHIELD PLANS, AND JOHN C. McCABE, PRESIDENT, MICHIGAN BLUE SHIELD; ACCOMPANIED BY JOHN W. CASTELLUCCI, EXECUTIVE VICE PRESIDENT, NATIONAL ASSOCIATION OF BLUE SHIELD PLANS, AND JAMES D. KNEBEL

Dr. ACKERMAN. Mr. Chairman and members of the committee, I am Dr. Carl R. Ackerman, a practicing physician in New York City and chairman of the board of the National Association of Blue Shield

Plans. With me is Mr. John C. McCabe, to my right, president of the Michigan Blue Shield, and Mr. John W. Castellucci, executive vice president of the National Association of Blue Shield Plans, and Mr. James Knebel. The association coordinates the activities of 84 Blue Shield plans in the United States, Puerto Rico, and Canada, which provide prepaid medical and surgical coverage for 59 million people.

Additional millions who do not have regular Blue Shield protection or supplementary coverage to medicare are served by Blue Shield under various governmental programs including titles XVIII and XIX of medicare, military dependents medical care program, and State and local welfare programs. Thus, Blue Shield is today serving some 70 million persons—64.5 million of whom are residents of the United States. This represents about one-third of the U.S. population.

It is a privilege for me to appear before you today to discuss Blue Shield's overall experience with part B of title XVIII, and to present our recommendations for improving the administration of this program. We are also pleased to have the opportunity to comment on those sections of H.R. 5710 which relate to titles XVIII and XIX.

As part of our presentation, Mr. McCabe will describe the actual administrative experiences his plan has encountered, which are typical of various other Blue Shield part B carriers.

BLUE SHIELD AND MEDICARE

Mr. Chairman, as you are well aware, after the passage of medicare, 33 Blue Shield plans were selected to serve as part B carriers for 60 percent—roughly 10 million—of the beneficiaries. It is important to remember that prior to medicare, Blue Shield was providing medical-surgical protection to some 5 million of the Nation's aged, and has first-hand knowledge of their needs.

We are oriented toward providing benefits in a smooth, trouble-free, efficient manner with the least amount of administrative expense. The primary intent of our testimony today is to suggest methods to simplify part B as much as possible so that we can provide the same excellent and helpful service to those aged whom we serve under medicare.

Blue Shield has had a quarter century of experience in prepaying medical and surgical services. It has underwritten many national programs—both private and governmental—and it has met its responsibility successfully. Today, seven out of 10 of the largest industrial corporations have Blue Shield for their employees.

In a new program, we are always aware that problems will arise and that it takes time to solve them. Medicare is a new and very complex program; some problems have arisen; and we are actively seeking solutions.

Since the passage of medicare, there were many ongoing meetings involving Blue Shield and consultations among plans as to the operation of the new program. On January 5, 1967, a meeting of chief executives of Blue Shield part B medicare carriers was held at which it was agreed that the National Association of Blue Shield Plans should set up evaluation teams to visit carrier plans. The purpose of these visits was to critique the medicare operations and make recommendations to improve the administration of the program.

The evaluation teams were organized and began visiting plans on January 30. Thus far, all but seven of the 33 plans have been visited, and the other evaluations will be completed, we expect, by March 10.

Our study showed that the management decisions by the plans—an essential ingredient to effective operations—have been taken away by restrictive regulations and voluminous and detailed administrative instructions. Furthermore, the centralization of the records at the social security headquarters in Baltimore, and the statistical requirements imposed under part B are making the program unduly complicated, cumbersome, less efficient, and more costly.

Despite these difficulties, we found that most of the plans are performing well. Where needed, we are arranging technical assistance.

But a key point we wish to make is that under present arrangements, carriers can keep up with the incoming claims only at the expense of an all-out effort and extra hours of work. This means, of course, high administrative costs.

CARRIER ROLE

Mr. Chairman, recognizing that it is not always fair to quote a public figure but with a firm confidence in your legislative knowledge and sincerity, I would like to recall your view of the part B carrier role. In an article in the February 1966 issue of *The Reporter* published by Medical Service of the District of Columbia you were quoted as follows:

The formula of administration we devised in the Committee on Ways and Means, we believe, will preserve all of the prerequisites of the medical profession while helping the aged meet the cost of necessary physicians' service. Our plan was based, to a large degree, on the experience of the Blue Shield organization. Under the medical insurance programs, private organizations, such as yours, will play an even greater role than their role in the hospital insurance program. The administrative role of the carrier is extensive—it carries on almost all of the activities it would undertake if it was the actual insurer rather than the agent. The Department of Health, Education and Welfare oversight of the program is restricted, in the main, to the contract renewal process.

We are deeply indebted to you, your committee, and Congress for your wisdom in seeking to make extensive use of the experience and abilities of private carriers to administer the program. This concept of the part B carrier's role is the one we think is implied in the law and the one envisioned by Blue Shield plans when they applied for the carrier role.

It also parallels the thoughts of the Secretary of Health, Education, and Welfare, John W. Gardner, when he addressed the American Medical Association's Conference on Public Law 89-97, October 1, 1965, in Chicago.

The new financial arrangements, the Secretary said, will "bring no drastic departure from insurance procedures familiar to all."

At this same meeting, Mr. Arthur E. Hess, Director, Bureau of Health Insurance, Social Security Administration, told the conference that he believes Public Law 89-97 represents—

a vote of confidence in policies and procedures worked out in the voluntary sector by third-party agencies. It reflects a conviction by the Congress that the voluntary organizations that have been engaged with the help of medicine in financing health care can be entrusted with added public responsibilities.

During the many months of work that went into the implementation of medicare, we were greatly impressed with the dedication and energy of the Social Security Administration staff. They were able, through herculean effort, to get the administrative machinery assembled to undertake this vast health-care program.

However, in their zeal to launch this new program, we believe they lost a certain perspective of the intent of the law and took away from carriers the management flexibility required to perform the very functions for which they were selected.

In the preimplementation period—July 31, 1965, to July 1, 1966—there were three broad issues that were of particular concern to Blue Shield: (1) Would the carriers have the recordkeeping responsibility with respect to the actual operations of the program? (2) Would the statistical reporting requirements place undue burdens on the carriers? (3) Would the carriers have the responsibility for determining reasonable charges?

Examinations of these three points are in order because they indicate the uncertainty and the sometimes rapid turnabout that marked this period. They also show key turning points which were to have great impact on the ongoing administration of the program.

RECORDS AND STATISTICS

Blue Shield Plans had anticipated that—consistent with good administrative procedures—they would be primarily responsible for the recordkeeping functions under the program. The carriers also believed that the requirements for providing statistical information to the Social Security Administration would pose little difficulty?

As late as January 1966 it was stated at meetings between systems people from the Social Security Administration and Blue Shield that the administration of medicare would be on a decentralized basis. The claim file and history record of each beneficiary was to be held by the carrier with only a record of payments by beneficiary recorded centrally in Baltimore.

On February 17, 1966—after the carrier selections were announced—the Blue Shield Steering Committee on Medicare met with the Social Security Administration staff, and learned for the first time that a reversal had been made in the recordkeeping approach. Social Security Administration representatives said they would maintain the current status of the deductible and the cumulative outpatient psychiatric payments. Social Security Administration said further that carriers would make payment only for services rendered in their assigned area.

With this decision, the complexion of the medicare program changed. Instead of carriers having control and immediate access to beneficiary records locally, they would have to rely on social security headquarters in Baltimore.

An area of particular concern to the plans has been the activities of the Office of Research and Statistics. Its staff had met with the representatives of the Social Security Administration, Blue Shield, and the commercial insurance companies on October 20, 1965.

At that time it was agreed that combining the administrative data needed for the processing of claims and statistical data for analyses

of the program would require a very complex reporting system, and certain uniform coding.

It was decided, therefore, to separate the administrative reporting from the statistical reporting, and that a minimum of information would be required for administrative purposes, such as name of beneficiary, claim number, and amount paid on his behalf. It was also agreed that for statistical purposes, a sampling of paid claims would be used. The Office of Research and Statistics indicated that it wanted a 5-percent sampling, which in view of the claims volume, appeared to be a high percentage.

On February 23-24, another meeting was held between the Blue Shield steering committee and Social Security Administration representatives. At this meeting, it was discovered that the Office of Research and Statistics of the Department of Health, Education, and Welfare now wanted fully punched paid claim cards on all medicare bills using a standard statistical coding system.

Blue Shield strongly opposed this. The committee pointed out that ORS was already getting a very high sampling of claims. The Blue Shield representatives also emphasized that it would be expensive and very difficult in the short time remaining to integrate a unique coding system into existing processing procedures.

Despite the Blue Shield steering committee's strong opposition to what it considers costly and unnecessary statistical requirements, word was received that the request of the Office of Research and Statistics had been approved.

The decision was to inflate the administrative costs of medicare because the expense of gathering these data would not be reported separately. I believe this situation may not only be of concern to us, but to those in government who are directly responsible for the performance of the medicare program.

REASONABLE CHARGES

The law and the criteria for carriers stated that the determination of reasonable charges under part B would be the responsibility of the carriers. The situation changed abruptly in March 1966 when the Social Security Administration conducted a series of regional medicare meetings in New York, Atlanta, Chicago, and San Francisco.

At these meetings, Social Security Administration spokesmen stated that in determining reasonable charges, the carriers would have to follow Social Security Administration guidelines and instructional material, and would be required to submit a report by June 1 setting forth how they intend to determine reasonable charges.

After issuing a series of documents on this subject, the criteria for determination of reasonable charges was just published in the Federal Register on February 8, 1967.

These regulations tend to define reasonableness of charges in accordance with rigid statistical formulas. Obviously, these rigid formulas do not allow the carrier to use its judgment, so needed to reflect the pattern or charges in its own locality.

MANUAL AND INTERMEDIARY LETTERS

On July 1, 1966, Medicare was theoretically ready to go into full operation. However, it became apparent that many important details had not been settled.

For example, the official part B intermediary manual was not received by the carriers until after the program went into operation, and there were significant changes. Prior to that time, the carriers had to base their preparations on a preliminary manual which was marked "For Discussion Purposes Only."

A key 89-page section of the part B intermediary manual dealing with fiscal administration was not issued by the Social Security Administration until August 5, 1966. And in the 8 months that the program has been in operation, 26 intermediary manual revisions have been issued.

Between March 25 and June 30, 1966, 76 intermediary letters were issued. Since July 1, 1966, the opening day of Medicare, 124 more intermediary letters were issued. Mr. Chairman, these 200 intermediary letters now total 1,017 pages.

The issuance of the many hundreds of changes made in the program through manual revisions and intermediary letters is to a degree understandable. Part B—as compared to part A of Medicare—is a new program and the Social Security Administration staff did not have a full appreciation of the administrative problems it posed. However understandable, these changes produced many delays in the handling of claims.

Furthermore, the continuation of the issuance of new regulations in an on-going manner will add further delay to the Medicare operation in the future. This issue needs clarification by legislation or regulation to enable plans to perform up to their capabilities in the future.

CARRIER EXPERIENCE

At this point in our testimony, Mr. Chairman, I would like to turn the microphone over to Mr. John McCabe who can describe his experiences as the director of a part B Blue Shield carrier.

The CHAIRMAN. Mr. McCabe.

STATEMENT OF JOHN C. McCABE, PRESIDENT, MICHIGAN BLUE SHIELD

Mr. McCABE. Mr. Chairman and members of the committee, my name is John C. McCabe. I am president of Michigan Blue Shield and I, too, appreciate the opportunity to appear before this honorable body to discuss the Medicare program.

Michigan Blue Shield is new to Medicare but not new to the health care business.

Michigan Blue Shield was organized in 1939, in the great city of Detroit and home of a distinguished member of this committee, the Honorable Mrs. Martha W. Griffiths.

Michigan Blue Shield was one of the first voluntary prepayment plans in the Nation. Today we are one of the largest. We pay out

more dollars for health care than any Medicare plan in the Nation, and we do it at one of the lowest administrative costs.

We are also proud to report that more than half of the 8 million men, women, and children in our great State are members of Michigan Blue Shield.

Our record of service to the community and our working relationship with the providers of care prompted us to apply for part B of the program.

It is to that stewardship I address my remarks today.

Michigan Blue Shield is responsible for payment of medical services for 691,000 persons enrolled in part B, or nearly 95 percent of the persons eligible for medicare in Michigan.

We have had to hire and train the equivalent of 293 full-time employees as against the 900 we now have and present plans indicate we will hire and train at least 150 more by the end of 1967.

We are proud of the fact that we have implemented medicare while operating a structure covering more than 4,250,000 Michigan residents, processing 3,133,000 claims per year and maintaining our leadership in the field.

We created an entire medicare operation unit where none existed before.

The Bible, if you pardon a reference to the Almighty, tells us of another great creation wherein the Creator rested on the seventh day.

But at Michigan Blue Shield—the seventh day is generally a work-day because we are trying to keep up with the claims volume and some of the additional layers of administrative activity generated from Baltimore.

The aforementioned comments are not made for self or organizational adulation. They are merely intended to indicate to this committee that we, at Michigan Blue Shield, feel we know something about medical economics and the administrative support work necessary in that field. More important, we think what we know and have in the way of expertise characterizes other Blue Shield plans.

What has happened in Michigan since July 1, 1966, has happened generally to Blue Shield plans serving as carriers for the Federal Government.

We have been swamped with letters, directives, and regulations from dedicated SSA officials. They have provided some of the answers we needed. And this is good. But at the same time they have often made it necessary for us to replan, retrain, and reprogram procedures in many areas of our claims-processing system.

These changes have been thrust upon us—and the other carriers—at a time when we have been swamped with operational problems arising from the newness of the program.

CLAIMS

Let me cite some examples. One problem concerns the condition of incoming claims. About half being submitted are “clean” which means they can be processed and paid without delay. The other half falls into a number of categories which require extraordinary handling. Some of these must be returned because they are incomplete. Others

must be suspended because information, which hopefully can be acquired without returning the document, is missing. Still other claims are received as a conglomeration of pieces of paper which must be transposed to documents with which the clerical staff can work.

One of the biggest paperwork problems results from the receipted bill requirement which prevents the carrier from reimbursing the beneficiary a portion of his medical expense unless he has receipts, properly made out and attached to request for payment forms. This, as you know, is the requirement in the law which means the recipient must pay the physician before his cost can be reimbursed. This becomes quite involved when the beneficiary has been treated by more than one physician.

The requirement is causing considerable dissatisfaction and some hardship to beneficiaries because they cannot pay their bills in full and thereby get the necessary receipted bill.

This matter is in urgent need of correction.

Beneficiaries are not happy with the bookkeeping required of them and they tell us. Others just send us a stack of receipts or bills and let us sort out those which are appropriate to medicare. Sometimes we get taxi bills. We have also had bills from their plumber.

Some elements of the work activity take three to four times longer under medicare than under the regular Blue Shield process.

Just how much extra work can be generated under medicare may be estimated through arithmetic developed by the Blue Shield plan in Topeka, Kan. Their mathematics show that the average Blue Shield claim requires 78 keypunch strokes while the average medicare claim has 312 strokes.

BENEFICIARY EDUCATION

Complicating the situation is the fact that we are dealing with men and women who by reason of age, infirmities and other circumstances do not understand or grasp the complexities of the program, yet they require and deserve extraordinary effort and patience. In this particular situation—this is characteristic of many Blue Shield plans—more than half of the people over 65 were on the regular program.

There is great need for an education program conducted by the carrier but the responsibility for such a program is now assigned to Government.

The Government has developed literature designed to answer most beneficiary questions, but the people continue to call us out of habit. Unwisely, a social security directive initially indicated that dealing with recipients was not a responsibility of the carrier and, therefore, no staff for the job was necessary. We knew differently and, fortunately, made some preparation.

Our own subscriber service telephone section which we share with Blue Cross of Michigan has 38 persons especially trained to answer all kinds of inquiries and constantly jammed.

We receive an average of 8,000 medicare calls a month. More than a thousand persons a month make personal visits to our headquarters office in Detroit seeking information about medicare. These statistics do not include some 20 branch offices around the State.

CENTRALIZATION

We have a problem relating to centralization of records at SSA headquarters in Baltimore and this problem, we understand, is common to other carriers. Under the present system, the carrier must query Baltimore by wire or exchange of magnetic tape concerning eligibility of an individual or the status of his deductible.

The requirement has caused considerable delays in processing and payment of claims. These delays have also created public relations problems for carriers, and I would suspect the government as well. Each plan has its own complaint about the query process, but it all adds up to the fact that days are added to the processing time and the incidence of error is compounded.

We are convinced that much time, effort, and money could be saved if recordkeeping were decentralized and each carrier given responsibility for those beneficiaries residing in its operating area.

STATISTICS

The problem of research and statistical requirements presently imposed on carriers has been mentioned previously, but I would like to touch upon it briefly.

These requirements have become a burden because they demand manpower at a time when manpower is in short supply, especially in skilled jobs and particularly in the larger metropolitan areas.

We recognize the importance of statistics but it is our considered opinion that some requirements are unnecessarily cumbersome and are adding substantially to administration costs.

For example, each carrier must code statistics for every bill processed and then keypunch a full payment record. I have a list of what is required if the committee is interested. Assuming projections are reached, all carriers administering the program will have transmitted upward of 25 million individual payment records for the first 12 months of operation.

Most Blue Shield plans, when dealing with their large customers, submit regular reports but not in the massive detail required under the medicare program.

Our regular reporting system has satisfied industry and we believe it would be satisfactory to government. Essentially, we suggest a system of sampling and audit because it would be simpler than the present method and it would be less costly.

In addition to the massive detail of statistics we must supply on the payment record, we must also reproduce 5 percent of all of the hard copy claims we receive and that includes attachments which come in all sizes, shapes, and forms. Then we must transmit the package to SSA's Baltimore headquarters.

We estimate the Office of Research and Statistics will receive several million copies of claims during 1967, which, of course, are all duplicated in the carrier files.

WORKLOAD REPORT

Each month carriers also must complete a workload report theoretically designed to summarize the month's activity according to the

number of bills in various classifications. This report requires a count and classification of bills from receipt to final handling involving certain criteria and determinations which must be made on a manual, census basis. Likewise, summarizations required to complete the report involve manual operations. These manual operations obviously prolong the work. In Michigan it takes us over 900 man-hours to accumulate the data for this report. We think it is excessive and so do many other Blue Shield plans. Recently SSA suggested that this report be expanded to encompass additional statistics for reasons we do not fully understand or accept.

SPLIT PAYMENTS

On the question of split payments, carriers must often make payments to two parties on an assigned claim. This situation arises when it has been determined that the beneficiary has already paid more than the deductible and/or the coinsurance amount to the provider of service. Accordingly, the reimbursable amount must be divided and handled by two separate checks—one to the physician representing the difference between his reasonable charge and what the beneficiary paid him, the other to the beneficiary in the amount of the so-called overpayment.

This has had two consequences for us: (1) From a financial standpoint, we have been late in issuing checks in our weekly payment cycles and (2) from a claims standpoint, we have been forced to hire and train personnel, including claims examiners, correspondents, and programmers. The split payment system causes an unrealistic and unbusinesslike response on claims payments because a doctor may receive \$17.02 and the beneficiary \$2.98. Even after we correctly complete the mathematical gymnastics, the beneficiary often calls and questions what we have done and why. Carriers who were asked to comment on the split payment technique were against it, but it was implemented anyway.

ADMINISTRATIVE PROBLEMS

The list of administrative burdens is long and tedious. No one has yet figured out how to satisfy claims payments involving deceased beneficiaries without making the legal process duplicated more often. Each case in Michigan is delayed an average of 3 weeks and each case requires 4 to 5 man-hours of sorting, phoning, and letterwriting.

We are responsible in some instances for collecting premium arrearages from beneficiaries, and they don't like that, either.

There is the problem of collecting signatures on 1,490 claim forms from the beneficiary or his representative payee, and the physician or the person rendering service. This causes processing delays and the question arises: are all these signatures necessary?

Sometimes we are called upon to determine whether a beneficiary could have used a taxi or a bus instead of an ambulance in getting to a hospital before we can decide under the regulations whether we should pay the ambulance bill.

ELECTRONIC DATA PROCESSING

Michigan Blue Shield, like so many other Blue Shield carriers, is using electronic data processing wherever possible. Its importance to

the successful administration of medicare in the face of increasing claims volume and the program's eventual growth is obvious.

However, it must be recognized that computers are highly sophisticated pieces of hardware which require highly skilled personnel to plan systems. Time to program the system is also essential, no matter how minor a change in the procedure may appear.

In less than 8 months, SSA has directed Michigan, and other carriers, to make 27 revisions in the system. Little or no leadtime was provided for programing such changes. We have been unable to keep up with it.

Let me repeat. SSA meant well but the revisions and the manner in which they were implemented often created more problems than they solved.

EFFECT ON REGULAR BUSINESS

Michigan has devoted considerable time and effort to medicare. We have borrowed from our management forces, our supervisors and our skilled clerical force. We have done so to demonstrate our ability to do the job and because we feel that medicare needed an extra push in its early stages.

You may properly inquire why these points are being raised today. There are two reasons: (1) to show the dedication and contributions of Blue Shield carrier plans to the medicare programs, and (2) to sharpen our request for any help which will relieve the carrier of unnecessary workloads.

Mr. Chairman, I have taken the time of this committee to relate some of the hard-core problems which confront Michigan and other medicare carriers.

We recognize that some of these problems grow out of the nature of the program.

We recognize that it is complicated and that it is one of the largest programs of its type anywhere. Yet, it also provides a delicate balance between the public and private sectors in both the philosophic and administrative sense and this we hope can be maintained.

We believe some of the problems lie in the law, some in the benefit program, and some in the centralized nature of certain administrative aspects, as well as some of the interpretations put on the law by officials responsible for its operation.

We are proud of the job we are doing in Michigan for the public, the doctor, and for the Government—and the other plans—and the Government can take its share of bows, too.

But, we are convinced and so are many of my associates in other Blue Shield plans that all of us, including Government, can and will do a better job if certain administrative relief is afforded.

For specific recommendations Blue Shield has to offer, I would like to refer you back to Dr. Ackerman.

Thank you.

The CHAIRMAN. Dr. Ackerman.

STATEMENT OF CARL R. ACKERMAN—Resumed

Dr. ACKERMAN. Mr. Chairman, there are five sections in H.R. 5710 involving title XVIII on which the National Association of Blue Shield Plans would like to comment. We will also include at this point

in our testimony Blue Shield's recommendations for improving the administration of medicare.

Mr. Chairman, section 125 of H.R. 5710 would extend medicare benefits to social security disability beneficiaries under age 65 and similar qualified railroad retirement annuitants. We respectfully recommend that section 125 be deleted from H.R. 5710 because we believe that provisions for these people who need such assistance can be made through title XIX programs.

Section 128 would increase the membership of the National Medical Review Committee from nine to 16 members. We support this proposal and urge that representation of part B carriers be considered in the expansion of this committee.

Section 130 would establish a special part under the medicare program which would provide for coverage of, and reimbursement for, specialty services furnished to hospital inpatients and services rendered to hospital outpatients. Frankly, while we have had an opportunity to look at this we are convinced we are not prepared at this time to fully explore and make recommendations as to this proposal, and if permission is granted we would ask that we could include our opinion at a later date.

The CHAIRMAN. We will be glad to have you do so.

Dr. ACKERMAN. It is recognized that the entire outpatient hospital and diagnostic specialty benefits provisions are badly in need of simplification. It is equally true that any proposal to simplify the administration of this portion of the medicare program requires careful evaluation to determine whether or not it meets the needs of the medical profession and the hospitals.

Section 131 would delete the present requirement in the medicare program under which a physician must certify, at the time an individual enters the hospital, that the hospital services are needed. We strongly support this amendment. There are existing procedures in hospitals which obviate the certification requirement as presently constituted, and we commend the wisdom of this proposal. We believe the physicians' action is adequate.

We support section 153 which would clarify the provision of part B benefits in cases where the beneficiary dies before reimbursement under the program is made.

Section 162 would permit the payment under part B for the purchase of durable medical equipment. Presently, the law permits such payment only with respect to rentals of such equipment. We think in the interests of efficiency and economy this change should be made and urge that the regulation specify that the decision as to whether to lease or to purchase be left to the carrier.

These are the comments we have on H.R. 5710 as it is presently written. However, we would strongly urge that another section be added which would be immeasurable assistance to the public, physicians, and the carriers in the operation of medicare. We strongly recommend an amendment which would allow the use of an itemized bill instead of a receipted bill where the claim is on a nonassigned basis. This would reduce a financial hardship to the elderly, and promote the flow of less troublesome claims to the carrier. The recognition of itemized bills for use in direct pay cases would be in keeping with procedures that have been used for many years by Blue Shield.

Mr. Chairman, and members of the committee, we have attempted to show in our testimony today that our capacity as carriers has not been used to the fullest extent. We firmly believe we have the capability and experience to administer this program more effectively, efficiently, and economically by participating in a more responsible carrier role.

We urge that a review be made of Public Law 89-97 with particular attention to section 1842. We urge that amendments to the law be made to clarify the responsibility of part B carriers.

So that carriers can utilize their expertise and administer medicare in a more efficient and economical way, we make the following specific recommendations:

1. Allow the carriers to exercise management judgment by letting them follow broad policy outlines issued by the Social Security Administration rather than be bound by strict and tightly strictered regulations.

2. Assign responsibility to the carrier to administer part B benefits for the beneficiaries residing in the geographic area it serves. This would mean a decentralization of the basic recordkeeping functions, and would involve the Social Security Administration only to the extent of providing carriers with eligibility beneficiary information. A major benefit that would accrue to the administration of this program would be the simplification of administering the deductible provision of part B. This would also provide the carrier with a degree of control over its claims-processing functions so that it would not be dependent upon Social Security Administration for minute guidance.

3. Place some limits on the statistical requirements under medicare. There is clearly a need for statistical reports to make certain the program is being operated efficiently, but these can be provided through simple reporting techniques. We believe a program to provide medical care should not be superseded by a statistical research program. If elaborate research studies are needed, they should be made through separate contracts and separate funds.

4. Authorize carriers to utilize their intimate knowledge of the local practice of medicine in making determinations for reasonable charges. We think this is the intent of the law.

Concerning title XIX, in H.R. 5710, we support in principle section 220, which would impose reasonable limits upon the income of people in whose medical expense the Federal Government will participate.

We support section 223, releasing States who "buy into" title XVIII from the obligation of providing comparable programs to all other categories of medical assistance.

Members of Congress and staff members of the Department of Health, Education, and Welfare have stated repeatedly that the major purpose of title XIX is to integrate the medically indigent individual into the community in terms of his access to sources of medical care. In other words, we endorse the principle embodied in section 226, permitting the individual eligible for medical assistance free choice of physician or hospital.

Mr. Chairman, in conclusion, we would like to express again our appreciation to you, this committee, and Congress for recognizing the need to utilize the ability of private carriers to assume a significant

role in the administration of medicare. We believe our recommendations will improve significantly the efficiency of the program while reducing its administrative costs.

We would like to emphasize that our comments are not meant in any way to detract from the hard work and the personal sacrifice made by members of the Social Security Administration staff in implementing this program. The Social Security Administration officials have been most cooperative and cordial in the contacts we have had, and we hold them in high esteem.

Again, may I express our sincere appreciation for giving us the opportunity to appear before you today.

The CHAIRMAN. Dr. Ackerman and Mr. McCabe, we thank you both for the statements you have made. I am sure your comments will be helpful to the committee.

I have just a few questions I would like to ask of you, Dr. Ackerman, and perhaps Mr. McCabe and some of the others.

You have not, as I understand, generally had experience in paying claims based upon reasonable charges. You have paid those claims in the past on some other basis, have you not?

Dr. ACKERMAN. Some of the plans have paid them on other bases. In some other cases, a few have had experience with reasonable charges.

The CHAIRMAN. You have had some experience, then?

Dr. ACKERMAN. Yes.

The CHAIRMAN. What adjustments had to be made in the method of operations on the part of those plans that had no experience, Dr. Ackerman, in paying on this basis of reasonable charges?

Dr. ACKERMAN. Well, I might preface the explanation with this explanation: That some time prior to the advent of medicare a concept of supplying 100 percent paid-in-full coverage to the public under a Blue Shield program had been under study and development and, to some degree, adoption to the extent that I mentioned before; that some plans had moved in this direction. So, consciousness of this approach to a usual and customary method of payment was widespread among the plans in the United States. The introduction of medicare emphasized the interest.

Prior to this, some of the plans which had not developed a program of usual and customary charges had already gone into the detail of collecting fee profiles.

Now, there is other experience that Blue Shield plans have used through the years. Every so often, in order to get a pattern of community charges, such fee studies have been carried on by plans so there is a background of trying to determine usual and customary charges. The change in pattern of payments would be in cycles of years.

Often in the past, a Blue Shield plan would adjust to this by increasing its fee schedule and the income level under which service benefits or payment in full, was being offered.

This development in medicare carrier plans has taken various approaches. Some went on with the development of profiles. Some, in reviewing their own background, realized that their level of payment, whether identified by a fixed fee schedule or by a relative value sched-

ule with an applied conversion factor—a dollar factor to this ruler or scale of relative fees—would be a way of representing it. Others had very high cooperation on the part of physicians in terms of one of their programs.

So, plans took various means to identify the usual and customary charges in preparation for medicare.

The CHAIRMAN. Then you didn't experience too much difficulty in making adjustment to this type of cost for payment purposes?

Dr. ACKERMAN. Where preparation or environmental economic conditions fit into it there was not great trouble. In some cases, plans were inadequately prepared with enough background material, although they knew that communities had a sense of where their fixed fee schedules were in relation to usual and customary.

The CHAIRMAN. Then can we assume that these adjustments have been made successfully?

Dr. ACKERMAN. Well, as far as we can determine in the overall, at the present time there has been very little complaint on the part of the public or doctor. There are instances where there is great satisfaction.

The CHAIRMAN. Would you, Mr. McCabe, report the same from your experience with your own Michigan Blue Shield operation?

Mr. McCABE. I think so. We would fall into the plan that had a historical experience on a fixed-fee schedule, actually, a series of fee schedules. We had to adjust ourselves to the variations and conditions that exist when income as a factor in the delivery of benefits is eliminated, which is true under medicare.

We have had some experiences which grow more out of ignorance and lack of understanding and a continuing ongoing program, especially with the physicians and the medical assistants. We have had meetings with medical assistants, about 6,000 of them in various meetings around the States where the process of communication is of great importance.

Disagreements and arguments as to whether our judgment is sound will come up under any program, as they do under this one, but still, in the first 6 months some 96 percent of the charges in Michigan were calculated at the level of the doctor's customary charge, and the others had to be sent for special review. So, by and large, it is good.

The CHAIRMAN. Dr. Ackerman, have you made any calculations within the Blue Shield operations to indicate whether or not costs under the medical insurance plan will be higher than we initially estimated them to be?

Dr. ACKERMAN. I would like to have that refined to whether it is overall costs for medical services or individual physician's charges.

On the one hand, since there is a shift of a portion of the population—and this relates to overall charges—from what was once classified as charity and programs of welfare, where perhaps low payments were made or services were delivered by physicians at no charge at all, certainly some of these costs have gone up.

We are in this program 8 months now, and this relates to a judgment of individual physician's charges. I don't think a relative measurement is yet possible within the course of the program. In the first place, we don't have enough data available now; it would take more time to identify the shift.

We are at a stage now where academic studies are being held back by our need and desire to get current in payments, and keep this program going full speed, so that I can't give you statistical findings on it.

The CHAIRMAN. Do you have a feeling, however, that they are higher than we had originally estimated?

Dr. ACKERMAN. I have a feeling, in terms of individual charges, that since the beginning of the program we have not noticed much change.

In the first place, there is a formula applied to the interpretation of "usual and reasonable," whatever that formula may be. Of and by itself, in a variety of situations where there is a fixed-fee schedule, the physician below that schedule possibly might move up under the schedule; we have no sure evidence of that.

Certainly, where profiles of charges are on file, physicians, as of now, have not been submitting a new and higher profile within the 8 months' period.

The CHAIRMAN. The comment is made that group hospital costs and costs for physicians' services have risen and that they have risen primarily because of the medical programs that we enacted in 1965. I have hesitated to accept this as a fact. You are lending some degree of backstop to the position I have taken. There has been no overall increase by physicians in charges just as a result of this program.

Dr. ACKERMAN. I do not feel there is. There has been, through the last few years, some increase annually of physicians' charges, the pattern of that perhaps reflects increased costs, but there has been this pattern.

If we traced the pattern of physicians' charges through the last 20 or 30 years, we find a period for 15 or 20 years when physicians' charges increased very moderately. In fact, we dallied behind almost all other charges for many years, so that such adjustment as has occurred within the last 10 years may be in response to something new.

The CHAIRMAN. Well, to attribute it all to the impact or the enactment of the medicare program is what I am getting at.

Dr. ACKERMAN. I feel medicare has very little relation to such change as may have occurred.

The CHAIRMAN. The hospital people will be here to testify some time this week, I understand. I am sure they want to note other factors that have brought about most of the increases in their charges. There are those who seem to feel that this program has brought about these increased costs and that is why I was asking you these questions.

To what extent have you applied the provision of the law which states that charges paid can be no higher than those for your own subscribers?

Dr. ACKERMAN. Well, if you will add to that, "under comparable circumstances," I think I would have to individualize Blue Shield plans.

Where a Blue Shield plan was reflecting total payments of physicians' services in its own program, this would be an instance where circumstances were comparable. Very often, other Blue Shield plans use the same mechanism, based on the philosophy of full payment below a certain income ceiling, always realizing that they are receiving a concession from physicians as to usual and customary fees in terms of servicing people of lower income.

The plans did not—and in discussion with the Social Security Administration where there was agreement—consider that these were “comparable circumstances.”

So, under usual and customary fee programs, in such plan areas, the payment would usually be at a higher level, as compared with a low or modest ceiling, service-benefit, fixed-fee schedule.

The CHAIRMAN. Dr. Ackerman, during the past year, have you had to increase any of the rates of your own policies and plans aside from the medicare program?

Dr. ACKERMAN. I am afraid I cannot report for the country, but I am on the board of the New York plan and those rates have remained steady for the past 10 or 12 years now with no increase. In general, the pattern of the Blue Shield rate increases does not correspond to those of Blue Cross where hospitalization costs are involved.

The CHAIRMAN. That is what I was trying to get to.

Dr. ACKERMAN. They were usually much longer intervals and as long as 4 or 5, 6, in fact in the case of New York some 12 years have passed without a rate increase in Blue Shield programs.

Now, that is not the full story, because sometimes, when a new program comes in, for instance, at a higher income ceiling with other fee schedules there will be a new rate. In other words, it will be at the rate of today, not at the rate of some older program.

The CHAIRMAN. But you have not had the problem of increased costs of carrying your program comparable to that which Blue Cross has had.

Dr. ACKERMAN. It is much less.

The CHAIRMAN. Representing, of course, less rise in the charges for the services that you cover, I would assume.

Dr. ACKERMAN. Yes.

The CHAIRMAN. Mr. McCabe, have you in Michigan had to increase your rates in the last year?

Mr. McCABE. Not in the last year; no. The last increase we had in Michigan was in 1963, in Blue Shield.

The CHAIRMAN. Has the medicare program, itself, and your operation of it as a carrier in Michigan in any way given rise to increased cost of administration, based upon all this paperwork that you mentioned?

Mr. McCABE. Not with respect to the regular program; no.

The CHAIRMAN. You separated where there was overlapping so that any of the costs that you may undertake with respect to medicare have not been in turn reflected in any increased rates in Michigan?

Mr. McCABE. That is right.

It is not separated but we have what I hope is a reasonable precise system of cost allocation; that is, there are very few people who work for Blue Shield who do nothing but medicare.

The CHAIRMAN. I understand.

Mr. McCABE. We have an integrated program and keep everybody happy as to who is being charged for what.

The CHAIRMAN. You don't know of any of the State organizations or State plans that have in mind any increases in the rates for their plans in the near future?

Mr. McCABE. No; and I think this is a constant.

Other than those broad examinations of our situation which are necessary from time to time, we have not had a change in the case of Michigan in our schedule of payments since 1959.

The CHAIRMAN. That is a rather consistent record.

Mr. McCABE. Yes, and the doctors are a little restless, I might add. Medicare has sharpened this a little bit, as has the general tendency for inflation in the economy generally.

So, I think except for this, you can exclude the factor of medicare, but it is not the predominant factor; it is just part of the total situation.

The CHAIRMAN. There are other factors that make a contribution.

To what extent have the Blue Shield plans which are carriers of a medicare program used existing review mechanisms in the administration of medicare?

Are you permitted to do that and to what extent have you done it?

Dr. ACKERMAN. I am not talking with a high degree of accuracy, but it is my impression that most of them are using the same facility or setup or organization that they have been using heretofore.

The CHAIRMAN. Then you are not required to make any change with respect to the review mechanism that has been utilized?

Dr. ACKERMAN. I would say with fair confidence that most of the plans are going along using the same mechanism and calling upon these committees, whether county society committees or committees made up of multiple counties, to do these reviews for medicare.

The CHAIRMAN. They have been reasonably successful over the years; have they not?

Dr. ACKERMAN. I believe they have; yes, sir.

The CHAIRMAN. The primary concern about that is that you think it is not absolutely necessary in your function as a carrier, as I understand your testimony.

Dr. ACKERMAN. The degree of freedom of action so that we can apply the judgment of each plan to its programs.

The CHAIRMAN. Do you expect that any of your carriers, Dr. Ackerman, will want to get out of their contracts this year or at the end of this year?

Dr. ACKERMAN. I think the involvement of Blue Shield, both locally and nationally, in this activity is such that we feel that any abandonment at this time would be a loss of prestige and significance, and so on. I am not talking without taking a vote, but I believe that they will want to remain in it, and to try to help this program.

The CHAIRMAN. You naturally want to carry it forward and make it a success. I understand that, but in view of all the paperwork you referred to, whether they would balance it off in the first year—

Dr. ACKERMAN. I think in what has been a relatively new career maybe we have been optimists and we hope that adjustments will occur.

The CHAIRMAN. You, of course, are aware of the fact that when we reported this legislation in 1965, on page 47 of the committee report, under actuarial cost estimates for the hospital insurance system, there was certain language requiring the agency to take an actuarial sample of the cost.

Is that why all this paperwork is required or paperwork, unrelated to this, in addition to what is normally considered—

Dr. ACKERMAN. Some of it is related to that. If there is a shift from a 5-percent sampling to a 100-percent recordkeeping, this becomes a much more difficult and extensive bit of work to do.

The CHAIRMAN. I know we were talking about one-tenth of 1 percent of all eligible individuals, not these millions of people that you are talking about. How much would that be, one-tenth of 1 percent of all those who are eligible? It is about 20,000 people.

We want information with respect to about 20,000 cases, not millions of cases, one-tenth of 1 percent. Maybe we should lower the percentage.

Dr. ACKERMAN. Or maybe we better use that percentage.

The CHAIRMAN. When we go into executive session, maybe we can get our blackboard and our crayons and decide which of us is correct mathematically.

Now, you made the statement in your presentation that you wanted us to delete this provision having to do with the inclusion of those under 65 who are disabled. Why?

Dr. ACKERMAN. We have always believed that there is a place for health assistance and full assistance to those who need such care. I think the requirements of the particular people you identify, closely associated as they may be with illness, rather than being met through a program like title XVIII should be protected by the comprehensive coverage of the title XIX program. For those who need the financial aid this would be a more satisfactory program.

The CHAIRMAN. Of course, if all the States would immediately implement title XIX and do so on a reasonably satisfactory basis, perhaps that would offer some solution to their medical problems. I don't know how much time finally it will take to fully implement it to that extent.

I have had a great deal of sympathy for the person who is disabled and has lost his income as a result of that disability, who might really be in worse physical shape, so far as medical needs are concerned, than a man who is 65 but who continues to work at his job.

It has been difficult for me to always reconcile the conclusion of an individual should receive this coverage just because he is 65 years of age even though he may still be working and to deny that coverage to an individual who is at home unable to do anything because of a heart attack or some other condition which it incapacitates him completely.

I thought perhaps you might have had some experience in this field in the operation of Blue Shield that might throw up a flag of warning to us concerning the costs or something of that sort.

Dr. ACKERMAN. Only my experience in the practice of medicine, that these would be people who would require rather comprehensive coverage. In other words, if there is a hardship situation, it would be rather complete, I agree with you. And if comprehensiveness of the program would be a factor, it would be available in XIX as a full program and he would get everything if he needs it. It might do that individual who needs it that much more good.

The CHAIRMAN. Doctor, this morning you were in the room, were you not, when Mr. Pettengill made the suggestion that we provide a third alternative for the payment procedures under part B?

Dr. ACKERMAN. Yes.

The CHAIRMAN. Have you had an opportunity to consider such an alternative in your Blue Shield plan? If you have, what comments do you have?

Dr. ACKERMAN. By and large, Blue Shield has not used that type of approach. We have been satisfied with a valid indication of a bill that has not been paid, and we have had no problem in terms of handling such matters as to honesty and the assurance of payment.

So, here we do have a program with two methods of payment now, one on the consignment basis and one on billing, and we have been mentioning some degree of complication. If we end up with three alternatives, it may be another complicating factor. Certainly, if we had the assurance that you could pay on an itemized bill, then the other requirement would not be necessary.

The CHAIRMAN. Would you consider your itemized bill suggestion as alternative to his alternative suggestion?

Dr. ACKERMAN. Yes, and I feel that there is a need for public relief in this matter and I present that as the alternative.

The CHAIRMAN. Is it your experience in Blue Shield that about 50 percent of the doctors ask for an assignment and the others direct payment?

Dr. ACKERMAN. It is a nicely balanced way of answering, but I would say the pattern varies throughout the country, and I think we are going to see shifts in the pattern until finally there may be a few diehards who feel they never should use the form as such. But I think the final pattern will be one of a physician using the assignment form for the person of low income and perhaps using the form or not using it with people of higher income. I think this will vary among the individual practicing physicians. I have been watching this develop: not that one does one thing but that he does both things.

The CHAIRMAN. Any further questions?

Mrs. GRIFFITHS. I would particularly like to thank you for your testimony. I enjoyed it very much.

The CHAIRMAN. We are very proud of Mrs. Griffiths. You saw fit to take notice of the fact that she is from your city of Detroit, but she is from all over the United States, as well. We are proud of her.

Mr. COLLIER. Mr. Chairman.

The CHAIRMAN. Mr. Collier.

Mr. COLLIER. Is there any administrative difficulty arising out of the fact that Blue Cross or Blue Shield are organized regionally? Has that delayed the process of submitting these claims at all?

For instance, in a typical case, does the hospital or doctor have to submit a claim to his regional headquarters? Does he have to go to Chicago or some place like that?

Dr. ACKERMAN. No; none of that has occurred. Actually, the Blue Shield national organization is a federation of the plans; all operations are local.

Now, in the Blue Shield plan coverage, speaking of medicare, cooperative arrangements have been made among the plans, so that when a national organization takes Blue Shield coverage this is parceled out. This is on a most efficient basis because it is all done locally and there is no need to go to any central headquarters for any clearance or anything like that once the basis of the contract is established.

Mr. COLLIER. Thank you.

The CHAIRMAN. Yes, Mr. Bush.

Mr. BUSH. Mr. McCabe, on page 18 you state you are responsible in some instances for collecting premium arrearages. Why would you have that?

Mr. McCABE. Some 10 percent of those eligible for medicare are still employed and, therefore, not receiving monthly cash payments.

Mr. BUSH. I missed that, sir.

Mr. McCABE. They are not receiving monthly checks from which deductions for part B can be made so they have to pay their premiums directly as individuals.

Mr. BUSH. Have to be self-employed?

Mr. McCABE. No. They may continue to be employed or they may be employed over 65. If they become delinquent in this payment and services are rendered, we are supposed to deduct from that payment the premium due, in a nonassigned case only. If it is an assigned case, we don't.

In some unassigned cases, we are to deduct the amount due from the cash payment or the payment that will be paid for the medical services.

Mr. BUSH. Isn't this a very unusual circumstance?

Mr. McCABE. It is very a unusual circumstance under medicare. Frankly, it is one of the administrative requirements and we would like to see it not included.

Mr. BUSH. Do employers sometimes have the option of giving people coverage under medicare or under a private coverage plan if they are over 65 years of age?

Mr. McCABE. They do; yes. Most of them, as a matter of fact, did wind up suggesting part B enrollment, and in Michigan, very few people wish to maintain the old benefit program.

Mr. BUSH. Thank you.

The CHAIRMAN. Any further questions?

Mr. UTT. No.

The CHAIRMAN. Again, Dr. Ackerman and Mr. McCabe and the others at the table, we thank you for coming to the committee to discuss these matters with us. We appreciate your answers to the questions.

(The following material was received by the committee:)

SOCIAL SECURITY ADMINISTRATION COMMENTS ON TESTIMONY BY REPRESENTATIVES OF NATIONAL ASSOCIATION OF BLUE SHIELD PLANS AND COMMERCIAL INSURANCE ORGANIZATIONS SERVING AS CARRIERS FOR SUPPLEMENTARY MEDICAL INSURANCE UNDER TITLE XVIII

Representatives of the National Association of Blue Shield Plans and commercial insuring organizations testified before the Ways and Means Committee on March 6 1967, on the experience during the first months of medicare of the 33 local Blue Shield plans and 15 commercial insurers who have been participating as medical insurance carriers. The representatives advised the Committee, among other things, that certain administrative actions taken in launching medicare impeded that ability of the carriers to perform those functions for which they were selected. The Committee was advised that the principal areas of concern relate to: the decision to maintain basic eligibility records for medicare beneficiaries at the Administration's central headquarters; the assigning to carriers of responsibility for making payment for all services rendered in a specific area instead of responsibility for making all payments for services rendered to beneficiaries in their specific area regardless of where the services may have

actually been performed; the statistical requirements for the Part B program; the guidelines for determining reasonable charges issued as proposed regulations; the volume of administrative and policy issuances since the program's inception; and the role of the carriers in providing program information to medicare beneficiaries. The Social Security Administration is furnishing comments on these items.

The areas of concern encompass very basic elements involved in the medicare administrative and operating framework. In the planning that preceded the establishment of this framework, the Administration secured the counsel of a broad array of experts in the health care field. Eight work groups of outside experts were convened—one in each of the most difficult technical areas to assist in policy and procedure development. Additionally, a special work group consisting of representatives of commercial insuring organizations and Blue Shield plans met with Social Security Administration staff on several occasions beginning in the fall of 1965 to furnish advice and counsel on the type of recordkeeping system to be established for medicare beneficiaries and alternatives for establishing carrier service areas. The Health Insurance Benefits Advisory Council (HIBAC) comprised of persons outstanding in medical, hospital, and other health related fields, also considered the various matters of concern with reference to the role of carriers in the program; and the Council reviewed in depth the policies and guidelines for determining reasonable charges as well as all other major policy issuances. The program's statistical requirements were reviewed and endorsed by a special Advisory Committee on Health Insurance Benefits Research and Statistics consisting of persons prominent in the fields of health and medical research and statistics. The Administration's comments follow:

1. Maintenance of Basic Eligibility Records for Medicare Beneficiaries

The Administration evaluated a number of factors before reaching a judgment that medicare eligibility records should be maintained centrally instead of by the participating carriers. The following considerations were predominant in leading to the decision to have the eligibility records maintained centrally: (1) The Administration has to maintain a master eligibility record on all social security beneficiaries centrally to administer its retirement, survivors, and disability programs and if the carriers maintained eligibility records they would be performing a duplicate and relatively costly recordkeeping function; (2) Through the premium collection process, long-established beneficiary reporting procedures and the on-going enrollment process, the Administration is informed of situations requiring accretions to or deletions from the eligibility records. If carriers maintained eligibility records, the Administration would need to establish additional subsystems for furnishing each contracting carrier information about accretions or deletions as new beneficiaries become enrolled or because of death or failure to pay premiums timely, and each carrier would need to establish procedures for the timely updating of its records to reflect these changes; (3) If the records were decentralized, the carriers selected to process billings probably would have had to be limited to those with well developed computer capabilities as they would have to handle volume transactions daily in recording information about the extent to which the deductible has been met and changes in beneficiary entitlement (see item 2) to assure eligibility records are current to process bills, and this would have ruled out the selection of a number of carriers that in other respects had the resources for performing the Part B carrier functions; (4) An additional set of arrangements would have to be established among the Part A intermediaries and Part B carriers so that the former could obtain from the latter information about the Part B deductible status where Part B services are furnished by hospitals or home health agencies and are reimbursable by the Part A intermediary; (5) The problem of referring to the central record is not as great as it may at first appear because once the carrier is advised the deductible has been met for a beneficiary, it does not need to refer to the central source for data on that beneficiary for the remainder of the year.

Within a few months, all but ten of the medical insurance carriers will be able to obtain information on beneficiary eligibility from the Administration's central records via use of high-speed wire transmission systems. Many carriers already use this resource and are able to obtain information from the central records within an average of 1 to 2 days for the vast bulk of bills received. If carriers maintained records for beneficiaries residing in the geographical area they service, they might be able to reduce slightly the present 1 to 2 days elapsed

time that it takes to obtain information from the central records using the wire system. But they would need to establish an inter-carrier data transmission system for exchange of deductible and entitlement information on beneficiaries who move from one carrier area to another or a system for transfer of files between carriers. This would add another dimension to the claims process that would increase administrative costs and if files had to be transferred it very likely would increase processing time.

2. Carrier Service Area

The NABSP and the commercial insurers initially took the point of view that carriers should be assigned responsibility for servicing a segment of the medicare beneficiary population. By way of contrast, under the present administrative pattern, each carrier is assigned responsibility for processing bills for services provided by physicians and other persons rendering services in a specific geographical area. (The sole exception involves railroad retirement annuitants whose claims are processed by a single carrier no matter where they reside. This carrier has worked out special procedures with the carriers servicing social security beneficiaries to assure that its payments of medicare bills for railroad annuitants is consistent with the payment of medicare claims for social security beneficiaries.)

A major reason for using commercial insurance organizations and Blue Shield plans as carriers in the medical insurance program is that they have experience in determining charges for medical services and in reimbursing physicians for services and indemnifying patients for expenses incurred. And, an ever increasing number of physicians and other persons supplying medical services have, in recent years, become accustomed to relating closely to the commercial insuring organizations writing health insurance and the Blue Shield plans. The Administration concluded that in structuring the administrative pattern for the medical insurance program, the pattern of close carrier physician interrelationship that had developed in the private sector should be transposed to the medical insurance program, and that this pattern would also facilitate the carrier's performance of its principal responsibility for determining reasonable charges. Thus, each participating carrier was assigned responsibility for making payment for services rendered by all physicians or other suppliers of services located in a distinct geographic area. This administrative approach encourages a close carrier-physician relationship, and it facilitates reasonable charge determinations because carriers are able to become familiar with the charge patterns of physicians and other suppliers of services located in the area they serve. This arrangement is also a convenience to physicians as it eliminates their having to deal with a number of different organizations, all administering the medicare program in the same geographical area.

Some beneficiaries have occasion to obtain services in different parts of the country and other beneficiaries change their residence and obtain services from physicians or other persons in the new locations to which they move. It would be very difficult for a carrier to make reasonable charge determinations consistent with those of other carriers dealing with the same physicians or other suppliers. A carrier would have a major problem determining the reasonableness of the charges since in some areas the carrier may not necessarily be familiar with the customary and prevailing fees. It would be possible to assure consistency in reasonable charge determinations where a carrier receives a bill from a physician located in a part of the country outside the area of residence of the beneficiary only if the carrier upon receiving the claim would transfer it to the carrier in whose area the physician resides. However, if this were done, the net effect would be that substantially the present administrative pattern would be followed since carriers would then be processing only bills for services rendered in their area, but there would be an additional processing step of transferring claimants among carriers which would increase administrative costs and processing times.

3. Statistical Requirements

The Part B carriers are not asked to produce statistical tabulations as such. They are asked to provide a flow of by-product data for program management and evaluation. The data that carriers are asked to submit are derived from the bills that carriers process to make payment to beneficiaries or physicians and other suppliers of services, or these data have already been compiled for use in the bill payment process. For example, in the course of the bill payment process

carriers extract information such as the type of procedure, the amount of the charge, and the place of the procedure. This information is used to develop data on physical charges and utilization as a basis for making reasonable charge determinations and making proper claims payments. It would need to be collected even if it were not sent to the Social Security Administration. This information is furnished on a payment record prepared by carriers on bills paid to or in behalf of a beneficiary as a basis for verifying payments made under the medical insurance program. As such it serves as the principal control for assuring the fiscal integrity of the program. The payment record is prepared on tape or punched cards and for most carriers is produced as a direct by-product of their bill payment process. Carriers are also requested to furnish a 5 percent statistically derived sample of the bills paid to or in behalf of enrolled persons.

The requirements for Part B carriers to submit both payment records and a 5 percent sample of actual bills are interdependent. In planning the health insurance statistical program, the Administration, in consultation with outside health and medical research statistical experts, determined that a 5 percent sample, if supplemented by certain other program data carriers would be compiling in the payment process and added to the payment record, would meet all of the needs for statistics and data about the program's operations for necessary program evaluation and decision-making, and would provide a basis for reporting to the Congress and the public on how well the program is accomplishing its objectives. Thus, carriers were asked to add this information to the payment record, instead of submitting a larger sample of bills. Most, if not all, Blue Shield plans prepare a payment record or paid claims card, following a manual of instructions provided by the National Association of Blue Shield Plans, for their regular business. The contents of the Administration's payment record and of these cards are quite similar. In fact, the information in the regular Blue Shield paid claims cards is to some extent more detailed because it often includes specific diagnostic and surgical procedure codes.

The contents of the payment record were purposely designed to minimize the expense of gathering the data. As part of its ongoing evaluation of intermediary and carrier reporting requirements, the Administration is looking into whether further simplifications for maintaining fiscal accountability and collecting data can be made through modifying the present system or by more fundamental changes. The Administration will be working closely with the carriers on this.

4. Guidelines for Determining Reasonable Charges Issued as Proposed Regulations

Section 1842(b) (3) of Public Law 89-97 contains two basic criteria for determining reasonable charges: (1) The customary charges for similar services generally made by the physician or other person furnishing the service, and (2) the prevailing charges for similar services in the locality. In no event, can the reasonable charge be higher than the charge applicable for a comparable service under comparable circumstances to the carrier's own policyholders and subscribers.

Following the selection of carriers to serve in the medical insurance program, the Administration undertook a series of meetings with them to discuss procedures for determining reasonable charges in terms of the statutory criteria. It soon became apparent that the carriers had widely differing concepts of the approach and process to follow in arriving at reasonable charge decisions. If the carriers were left to their own discretion in applying these concepts, it would not be possible to assure that the Part B carriers would achieve a needed degree of consistency in determining reasonableness of charges in a program national in scope. The Administration concluded that it would be necessary to furnish carriers with basic guidelines that would result in the desired consistency in reimbursing physicians, but which would permit sufficient flexibility for carriers to exercise judgment based on actual charges by physicians and special factors that may exist in individual cases, so that reasonable charges would be realistic and equitable.

In developing the proposed regulations on reasonable charges the Administration obtained the counsel of the American Medical Association and of other individuals and organizations with extensive experience in the area of reimbursement of medical insurance claims. While the proposed regulations are comprehensive and offer illustrations and examples of methods by which the determinations involved might be made by carriers, they clearly convey that they are guides rather than rigid operating instructions. Since the Administration wishes to

absorb into the administrative process the know-how and experience of the carriers in handling medical insurance claims, the regulations were written to emphasize that carriers should use judgment in applying the basic criteria and in using statistical formulae furnished as suggested aids to facilitate reasonable charge determinations. For example, in Section 405.503(b) the proposed regulations provide that where a physician varies his charges for a specific medical procedure or service, so that no one amount is charged in a majority of cases, "... the carrier will exercise judgment in the establishment of a 'customary charge' . . ." This Section then goes on and provides, as a guide, that carriers may use the median of the physician's various charges (excluding substandard as well as exceptionally high charges) in arriving at customary charges.

Section 405.504(a) suggests a statistical technique for determining the prevailing charges in a locality for a given service. Here also, the regulation itself emphasizes that "... the carrier will adopt an appropriate limit for each procedure or service with *judgment being exercised* to assure . . . the result is reasonable" (emphasis added).

The need for the carriers to exercise judgment goes beyond the definition of terms such as "customary" and "prevailing" charges. The carriers are also expected to use judgment in applying these terms. For example, Section 405.506 of the proposed regulations indicates there are circumstances under which a charge that is higher than customary or prevailing may be deemed reasonable by the carrier. The criteria of customary and prevailing charges are therefore not absolute and sole measures of reasonableness applicable under any and all circumstances, and carriers are informed that they must exercise a great deal of independent judgment in determining reasonable charges.

5. Policy and Administrative Issuances

To assure administrative and policy consistency among the participating carriers, operating procedures and information are issued through a Part B Intermediary Manual supplemented by a series of intermediary letters. It is quite customary, in the initial months of a new and complex program, for there to be a relatively larger number of instructional issuances than in a stable on-going program where there exists considerable operating experience.

The Administration issued a preliminary manual to the Part B carriers on April 14, 1966, and a "final" manual on July 19, 1966. The preliminary manual was marked "For Discussion Purposes Only" to indicate that it was not a final document. This device was followed to make available to the carriers for training and planning purposes the most comprehensive body of information at the time available on program administration. Besides this issuance, the Administration also sent to the carriers on April 14 the detailed specifications on the system for determining beneficiary entitlement and deductible status and for computer operations relative to the system. Detailed instructions on fiscal administration were issued on April 21, 1966, although they were not embodied in the manual until August 5, 1966.

While the bulk of operating procedures and methods were firmed up by April 1966 when these issuances were made, some refinements in methods necessarily had to be made as the Administration began its final evaluations and testings of procedures just before the program's inception. This was understandable in the launching of a program involving all of the complexities of medicare. Some of these refinements were made at the suggestion of the carriers as they began their pre-testing of program procedures. Where refinement or modifications of procedures were essential, these were conveyed to carriers through a series of intermediary letters designed for speedy issuance of information the carrier needed to have or through page replacements of draft materials previously issued. Many of the "changes" in the official manual issued in July 1966 were merely the incorporation of these previously issued materials into the body of the manual.

Many of the changes transmitted by intermediary letters and manual replacements contained simplifications of operating methods resulting from the experience acquired by the Administration or carriers as the program progressed; very few revisions were made in the operating methods that had been established. It is important that the issuance system be flexible and responsive so that improved and strengthened operating procedures can be quickly passed along to the carriers.

On August 30, 1966, an eleven-member group composed of carrier representatives was established to discharge the provision in the carrier agreements re-

quiring prior consultation by the Secretary on the contents of regulations and instructions affecting carrier operations. Through this group, carriers are on a continuing basis afforded an opportunity to participate in the formulation of proposed regulations and instructions prior to their issuance.

6. Providing Information to Beneficiaries

The Social Security Administration through its more than 700 local offices located in the principal cities and towns of the 50 States and Puerto Rico has general responsibility for providing information about the retirement, survivors, disability, and health insurance programs. Carriers have the principal responsibility for furnishing information in response to inquiries about the processing of specific claims and for preparing and furnishing to beneficiaries and to physicians accepting assignments an "Explanation of Benefits" form each time a Part B payment is made. Carriers are also responsible for furnishing program information to beneficiaries and to the general public in response to letters directed to the carriers' offices or personal visits to those offices. And they are a primary source for furnishing information about the program to individual physicians, medical suppliers, medical societies, and other physician and health care organizations.

Social security beneficiaries by long-established custom and practice turn to the district offices (a number of these also have branch offices and all have representatives that regularly visit outlying areas servicing people who live at a distance from the city or town in which the district office is located) for program information. These offices carry out a broad spectrum of activities geared to informing the general public and beneficiaries about their rights under the health insurance program and other programs for which the Administration is responsible. The Social Security Administration district offices have over the years built up extensive relationships with the various informational outlets at the local level and have had exceptionally good cooperation on the part of these outlets in providing informational materials about the health insurance program. Additionally the staff in these offices are quite knowledgeable about the medicare program and through long experience in dealing with the aged, have acquired excellent perception and insight into the unique problems of informing this segment of the population.

The Administration felt, therefore, that it would be duplicating and costly to superimpose another series of informational outlets on top of this existing resource. It advised carriers that in view of the existence of the social security district office network it would be unnecessary for carriers to establish individual offices in the carrier service area for the express purpose of providing information to beneficiaries and the public generally, about the health insurance program. Social security district offices have been advised that where information is requested about a specific claim which the district office is unable to respond to—for example, the basis for arriving at the amount of charges allowed—the district office should refer the person making inquiry to the carrier having jurisdiction since the carrier would have all of the facts available on which it made its decision. All carriers are aware of these arrangements. Many carriers have indicated that they prefer that the Social Security Administration attempt to handle as many inquiries as possible as they do not have the resources for handling a significant workload in the program information area.

Several months ago, the Administration worked out arrangements with carriers whereby carriers are able to use the resources of the social security district offices to obtain information from the beneficiary or other sources on incomplete claims. These arrangements also encompass the referral to the district offices of examples of beneficiary misunderstanding that are identified through carrier review of bills so that appropriate informational programs can be developed.

A REVIEW OF SOCIAL SECURITY ADMINISTRATION'S COMMENTS ON THE TESTIMONY OF MEDICARE PART B CARRIERS

(Prepared by National Association of Blue Shield Plans)

The Social Security Administration's comments on testimony presented by the National Association of Blue Shield Plans and Commercial Insurance Organizations serving as Part B carriers under Title XVIII have been carefully reviewed.

The comments only reiterate the position SSA has taken in the past, which NABSP has sought to modify for the sake of improving the administrative efficiency of the Supplementary Medical Insurance Program. SSA's paper attempts to rationalize its decisions and actions in implementing and administering Medicare, instead of reacting directly and constructively to testimony of those who have extensive knowledge and experience in the financing of health care.

The Social Security Administration contends throughout the paper that it has established various committees and liaison activities to obtain the views of the medical profession and the carriers. There is little argument that this has been done. The critical point, which was made in NABSP's testimony and which obviously must be made again, is that SSA has not followed the advice of these committees and groups on many key issues.

Shortly after Medicare became law, Blue Shield representatives were consulted by SSA, and devoted a considerable amount of staff time and talent to the Medicare program. As early as August 18, 1965, SSA asked NABSP to assist it by participating in Work Groups to confer with, and advise, the SSA staff. In one instance, the development of Carrier Qualification Criteria, many of Blue Shield's suggestions were accepted and were subsequently embodied in the published document. However, in the area of administrative operation, the advice and recommendations of the Work Group on Systems and Statistics, which had seemed to be acceptable to SSA staff, were subsequently rejected by SSA. It was replaced by a system concept which had been considered and unanimously opposed by the Work Group. This action by SSA occurred after the carriers had been selected and named. It is still NABSP's contention that the system does not lead to efficient administration.

In the hope that the current re-examination of the Title XVIII program will result in better service to the aged beneficiaries, the following comments are offered on the Social Security Administration's paper.

1. MAINTENANCE OF BASIC ELIGIBILITY RECORDS

In its comments on the section dealing with the maintenance of basic eligibility records for Medicare beneficiaries, the Social Security Administration's paper misses the point completely. NABSP's testimony did not urge that the carriers maintain the *eligibility* records the way SSA does. In urging a decentralization of the basic *record-keeping* function under Part B, NABSP pointed out that this would involve the Social Security Administration "to the extent of providing carriers with eligibility information."

What NABSP said in its testimony was that if the carriers were provided with eligibility information to maintain the status file for beneficiaries, this would eliminate the costly and time-consuming query process by all carriers to a central point. NABSP also emphasized that this would "provide" the carrier with a degree of control over its claims processing functions so that it would not be dependent upon SSA for minute guidance.

SSA states in its paper that "if carriers maintained records for beneficiaries residing in the geographical area they service, they might be able to reduce slightly the present 1 to 2 days elapsed time that it takes to obtain information from the central records using the wire system." This statement contradicts the experience of many Blue Shield carrier Plans, and also appears to display a lack of understanding of the query function. If a decentralized system is established, it would not "reduce slightly" the query time, but *eliminate* it entirely.

The point is also made by SSA that if records were decentralized, this would have limited carriers "to those with well developed computer capabilities." This after-the-fact comment is interesting since published Carrier Qualification Criteria stated that the carrier selected "should have an existing operational, statistical, and record-keeping capacity commensurate with the magnitude" of the Supplementary Medical Insurance Program.

It is stated by SSA that the system for inter-carrier exchange of data would increase administrative costs. However, SSA fails to acknowledge that savings to administrative cost through elimination of the query process should more than offset such new administrative expenses.

2. CARRIER SERVICE AREA

The Social Security Administration's position in this discussion hinges mainly upon the statement that "some beneficiaries have occasion to obtain services in different parts of the country and other beneficiaries change their residence and

obtain services from physicians or other persons in the new locations to which they move." Actually, the percentage of the aged who fall into the first category is insignificant in comparison to those who would otherwise establish permanent relationships with a single carrier within their geographic area. As for those aged who change their residence, status file records would be transferred to the carrier serving the area to which they have moved.

With regard to consistency in the determination of reasonable charges, this problem was resolved to everyone's satisfaction when the Railroad Retirement Board elected to use its own carrier and asked SSA carriers to cooperate in assuring consistent performance. The obvious question is: If consistency in determining reasonable charges can be achieved satisfactorily for RRB beneficiaries, why should it not work just as well when a beneficiary under Part B receives services outside his carrier's area?

The statement is also made that by assigning carriers to make payment for services rendered in a "distinct geographic area," the close relationship between the carrier and the physicians in the area would be encouraged. It should be pointed out that one of Blue Shield's strengths lies in the unique relationship it has with the medical professional and it does not need to rely on this program to develop closer relationships with physicians. Furthermore, the Criteria for Carriers clearly states that the carrier selected "should have the ongoing professional relationships essential to administering" the Medicare program.

3. STATISTICAL REQUIREMENTS

Blue Shield Plans do not object to providing necessary statistical data to SSA. They maintain, however, that the systems and procedures to obtain these data should be efficient and the cost of these procedures must realistically yield data of comparable value.

SSA implies that the statistical requirements under Medicare are no different from the payment record or paid claim cards that Blue Shield Plans prepare regularly. This is not true.

As emphasized in the testimony of John C. McCabe, President, Michigan Blue Shield, "most Blue Shield Plans, when dealing with their large group accounts, submit regular reports but not in the massive detail required under the Medicare program." Mr. McCabe pointed out that under the existing requirements, Part B carriers in the first 12 months will have transmitted upwards of 25 million individual payment records to SSA. He stated further that in addition to these statistics, carriers must transmit to SSA several million copies of actual claims as a result of the 5 percent sampling requirement.

These monumental figures become even more significant when it is recalled that the Committee on Ways and Means, in considering the Medicare bill, H.R. 6675, was discussing a sampling of 1/10th of 1 percent.

Medicare as it is now structured, is a difficult program to administer and carriers should not be unnecessarily encumbered by a massive statistical research program. If elaborate studies are needed, they should be made through separate contracts and separate funds so that they do not inflate unnecessarily the administrative costs of the Medicare program.

4. GUIDELINES FOR DETERMINING REASONABLE CHARGES

In its zeal to assure uniform performance in the area of determining reasonable charges—a function assigned exclusively to carriers—it appears that the action of SSA may be in conflict with the law. If the law is to be implemented as it is written, there will be variations in the determination of reasonable charges based on the carrier's expertise and intimate knowledge of the charges and the practice of medicine in the area in which it operates. Obviously, this is not in accord with SSA's position that strict guidelines are needed. It has come to the attention of NABSP that the Division of Reimbursement has already reviewed the performance of certain Part B carriers and criticized them for not conforming with the Regulations on Determination of Reasonable Charges. Thus, while these carriers may have been exercising their judgment and conforming with the provisions of the law, they were judged according to SSA's standards. SSA may maintain that its regulations are not rigid, but the interpretation by Federal agencies to which carriers must also answer may be otherwise.

5. POLICY AND ADMINISTRATIVE ISSUANCES

SSA's comments on the volume of manual changes and intermediary letters issued parallel the testimony presented by NABSP. However, SSA again fails to deal with the primary thrust of NABSP's testimony. Blue Shield contended that, instead of issuing many strict and tightly-structured instructions, SSA should offer broad policy outlines and allow carriers to exercise management judgment in implementing them.

SSA's paper serves to re-emphasize the point that the "final" manual on the program was not issued until 19 days after Medicare was in effect, and that a section dealing with instructions on fiscal administration was not embodied in the manual until 36 days after the program had been in operation. While recognizing the complexity and magnitude of the Medicare program, it must be pointed out that these delays caused considerable difficulties to carriers.

A similar problem to carriers has been the voluminous flow of Intermediary Letters containing instructions which Plan personnel must read and integrate into their Medicare operations. At this writing some 208 Intermediary Letters, totaling more than 1,000 pages, have been issued. At a Medicare Briefing Conference in Washington, D. C., on April 20, 1967, SSA indicated that at the present time only 83 of these Intermediary Letters were in effect. The point made in the Blue Shield testimony was that these constant changes add to the administrative burden of the program and slow down the efficient processing of claims. SSA has merely reinforced this point by admitting that the vast majority of these Letters have involved more than one administrative change.

SSA also stated that an 11-member carrier representative group was formed on August 30, 1966, in accordance with "carrier agreements requiring prior consultation by the Secretary on the contents of regulations and instructions affecting carrier operations." No mention, however, is made of the fact that 130 Intermediary Letters were issued before the carrier representative group was named, or why there was delay in establishing this group.

It is also stated that through this carrier representative group, carriers have a continuing opportunity "to participate in the formulation of proposed regulations and instructions prior to their issuance."

The following figures provide an insight into how this group was consulted. Of the 208 Intermediary Letters issued, the group was consulted on only 29. And of the 29, several were presented to the group upon its arrival for the meeting instead of giving time for prior consultation as required by the contract. Similarly, 32 revisions to the Manual have been issued and of these, the Committee has been consulted on only 11.

6. PROVIDING INFORMATION TO BENEFICIARIES

The comments of SSAAA pertaining to beneficiary service again fail to recognize the needs of the program as pointed out in Blue Shield's testimony. NABSP's testimony related to the position of SSA that carriers would not be involved in providing information to beneficiaries, and, therefore, were not authorized to staff for these purposes. While it may be true that the Social Security district offices have built up extensive relations with beneficiaries, these relations are not effective when applied to Medicare problems. It should be recognized that beneficiaries, who have questions about Medicare, naturally contact the local organization where the actual paperwork is being done and from where the payment for services originates.

In New York City, for instance, the Blue Shield Plan must maintain a staff of 90 persons to service telephone and personal inquiries on Medicare. As many as 500 persons a day have visited the Plan to seek information and help on Medicare, and about 50 percent of their questions relate to basic features of the program which were well explained in the literature on Medicare.

It is interesting to note that in regard to beneficiary services, SSA comments that "it would be duplicating and costly to superimpose another series of informational outlets on top of this existing resource." Meanwhile, in Intermediary Letter No. 207 dated March 29, 1967, SSA states that district office personnel will develop and implement programs that will involve personal contact with physicians. This obviously duplicates and superimposes the activities of carrier professional relations programs. Of greater concern, however, is that these new activities may seriously hamper and interfere with the fine carrier-physician relationships which exist today.

CONCLUSION

It is regrettable that SSA did not comment upon other items contained in NABSP's testimony that affects the administration and cost of this program.

For example, what of Blue Shield's suggestion that the receipted bill requirement be corrected so that the beneficiary will not have to face a hardship if he cannot pay his bill in full in order to obtain a receipted bill?

What can be done to eliminate the confusion over "split payments" to the physician and the beneficiary, when the beneficiary has already paid more than the deductible and/or the coinsurance amount to the provider of service?

Is it not possible to ease the signature requirement on the Medicare claim form so that obviously valid claims can be processed without the time-consuming process of sending them back for signatures?

By seriously weighing these and other suggestions, SSA may have been able to resolve some thorny problems that are preventing the carriers from serving the beneficiaries more efficiently.

The Committee on Ways and Means and the Congress wisely recognized the need to utilize the ability of private carriers and to have them assume a significant role in the administration of Medicare. Through Blue Shield's testimony and through these comments on SSA's paper, an attempt has been made to show that the capacity of carriers has not been used to the extent intended in the law.

The CHAIRMAN. Without objection, the committee will adjourn until 10 o'clock tomorrow morning.

(Whereupon, at 4:15 p.m., the committee adjourned, to reconvene at 10 a.m., Tuesday, March 7, 1967.)

PRESIDENT'S PROPOSALS FOR REVISION IN THE SOCIAL SECURITY SYSTEM

TUESDAY, MARCH 7, 1967

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met, pursuant to notice, at 10 a.m., in the committee room, Longworth House Office Building, Hon. Wilbur D. Mills (chairman of the committee) presiding.

Mr. WATTS (presiding). The committee will please be in order. We are very fortunate this morning to have as our first witness one of our colleagues, Congressman Zablocki, from Wisconsin. Come around, Congressman. We would be delighted to hear you.

STATEMENT OF HON. CLEMENT J. ZABLOCKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Mr. ZABLOCKI. Thank you, Mr. Chairman.

I am indeed grateful to have this opportunity to come before this committee to express my views on needed amendments to our social security laws.

I want to commend you and the committee for acting so promptly on the administration's proposed increases in social security benefits. I wish to express my own general support and endorsement of the program to strengthen and improve social security as proposed by President Johnson in his January 23 message to Congress.

The inflationary trend of the past year has caused the senior citizens of our Nation more hardship than anyone else. For many of them the subsistence line is indeed a thin one. A rise in food and other living costs means tightening the belt, doing without, and sometimes acute distress.

The President has acted to meet these problems facing the elderly by proposing a fair and reasonable increase in the social security benefits. It is my hope that the Congress will act responsibly and effectively to approve these boosts in social security payments.

Nevertheless, I am deeply concerned about the far-reaching implications of the President's recommendation that an increase in special benefits be made to 900,000 persons 72 years of age or over, who have made little or no social security contribution and provision of special benefits for 200,000 persons 72 years of age or over, who never before have received benefits.

While I believe that those increased and extended benefits are needed, such provisions—in addition to some innovations made in the

89th Congress—indicate that the social security program is turning away from its original insurance concept and is rapidly becoming a national social welfare program.

The idea behind social security was that a man during his lifetime could, through his labor for wages, put away in a national fund money which would return to him as a pension when he reached retirement age or was totally disabled.

Today we find more and more persons who never contributed to the social security fund reaping its benefits. The cost of including these persons is, however, still being borne by the individual wage earner. The result is that we are getting to a point where the Federal Insurance Contribution Act tax is becoming a burden to persons attempting to raise young families.

I am further concerned that by including many of the over-72 persons in the social security program we are only lightening the burden which the States traditionally have carried in providing welfare assistance.

At the same time, I recognize that some States do not have adequate programs to assist the indigent and that, as a result, many of our elderly poor must exist in conditions that constitute a shame for our affluent society.

My point, therefore, is this: If we are creating a national welfare program, let us be honest about it. We should abandon the idea of an insurance program which must be actuarially sound and financed by a special tax on wages. Perhaps the time has come to finance at least certain parts of social security out of general revenues.

It is my hope that my colleagues on the Ways and Means Committee will give this matter careful consideration as they work on the Social Security Amendments of 1967.

In two other respects I believe that the President's proposal does not go far enough in meeting real needs of our elderly.

First, I believe that the raise in the earnings exemption of 12 percent, from \$1,500 to \$1,680, is far too small. Rather, a more realistic amount would be \$2,000.

Many of my elderly constituents have told me of the financial difficulties which the current earnings limitation puts on them. They have small part-time jobs which keep them busy and at the same time keep them contributing needed skills to our community life.

Yet, often they are penalized for their enterprise by being denied the full amount of their social security benefit.

I further believe that the amount above earnings exemption up to which a beneficiary can retain \$1 in payments for each \$2 in earnings be increased from \$2,700 to \$3,000, instead of the \$2,880 recommended in the President's message.

My particular purpose in coming before you here today is to testify on behalf of a proposal in my bill, H.R. 6561. The measure amends title XVIII of the Social Security Act to permit an individual to be paid for charges by a physician under the supplementary benefits program prior to the individual's own payment for the charges involved.

I am pleased to be a cosponsor of this bill with a distinguished and esteemed member of this committee, the gentleman from Ohio, Mr. Vanik. He has introduced the proposal as H.R. 5509.

This legislation is aimed at easing the burden of payment on some medicare recipients, thereby remedying a serious difficulty which has arisen since the enactment of the medicare program in the 89th Congress.

As you know, Mr. Chairman, under the supplementary benefits insurance program, a doctor has the option of dealing directly with the Government to obtain payment or of requiring the patient to pay him directly.

The patient then sends the receipted bill to the Social Security Administration for reimbursement. The reimbursable portion amounts to 80 percent after the first \$50.

According to information I have received from officials of the Social Security Administration, in about 50 percent of cases doctors are unwilling to bill the Government directly. Some doctors refuse completely; others pick and choose among cases, apparently on their personal determination of the financial ability of the patient to pay.

The net result, therefore, is that in about half the cases which an elderly beneficiary of medicare uses the supplementary medical insurance he must first pay his doctor before he can obtain reimbursement from the Government. Further, often 3 months or more can elapse between the submission of a receipted bill and actual payment.

This situation is causing severe financial hardships for many of our elderly sick.

Mail from my constituents has been heavy with complaints about this procedure. It is my understanding that other Members of Congress have received similar letters.

Not long ago an elderly man wrote me that he had undergone rather major surgery. His doctor bills amounted to more than \$500. Because his physician would not accept assignment of the charges directly to the Government, he was forced to borrow the money and put his house up as collateral.

This involved considerable time, worry, and redtape, in addition to the payment of high interest rates on his short-term loan. Understandably, this man was bitter about the operation of the medicare program.

I could recite many other such instances which have come to my attention. In some cases persons have taken out short-term notes expecting quick reimbursement from the Government. When the weeks stretch into months and no money is forthcoming and the note is about to fall due, they are caused considerable anxiety.

In other instances, the trouble may lie with a physician who will not deal with the Government under any circumstances. Social security officials have told me of cases in which doctors have turned over the due bills to bill collectors rather than accept assignment.

Up to this time, the only recourse open to a medicare beneficiary was to make sure that his doctor would deal with the Government before incurring any charges.

Often, however, this is an impractical solution. First, few recipients are aware of this aspect of the law. They seldom think to ask the doctor about his policies. Second, because of circumstances an individual may have only one or two physicians to choose from. And third, when a patient has built up a relationship of trust with a doctor, he may be loath to seek help elsewhere.

The legislation which Congressman Vanik and I have introduced would provide an effective practical remedy to this problem.

It would amend title XVIII of the Social Security Act, under part B, in two ways: First, it would strike out the requirement for submitting a receipted bill to the Government. Second, it would substitute a provision for payment upon submission by the beneficiary of an itemized bill prepared by the physician or other persons providing services covered under the program.

This proposal would effectively lift the financial burden from the shoulders of the elderly person, while respecting the doctor's freedom to deal with, or not to deal with, the Government.

On March 3, in response to my request, Mr. Darell Coover, a representative of the American Medical Association, sent a memorandum expressing support of the principle underlying this legislation. With your permission, I will quote from Mr. Coover's statement:

The proposed change is not only consumer-oriented but it is also a reaffirmation of a belief in the physician-patient relationship. There are those who might say that paying the patient first could result in the patient not paying his doctor bill. This is a matter of a physician trusting his patient, which he has done in the past under the private practice of medicine, when he sends a bill to his patient.

He does not know for certain that the bill will be paid. He is putting his faith in the patient to pay when he can. The Zablocki bill would allow the same procedure under part B of Medicare. It is a statement backing the physician-patient relationship, which is so vital to the practice of medicine and to adequate health care.

If the bill is small, the patient might wish to go ahead and pay it and send it in for reimbursement. The receipted bill would still be acceptable.

There are two major advantages to this bill:

1. The patient will be able to be reimbursed first, before he has to put out any money. This creates no hardship for him.

2. He will know if the bill is approved by the Social Security Administration, as submitted, before he pays the physician. If it is not, then he has the opportunity of discussing it with his physician before he has paid out anything.

This procedure of allowing physicians and patients to continue a relationship which has been in existence for many years will help make the administration of medicare smoother.

This method of a physician's statement is backed by resolution of the House of Delegates of the American Medical Association at its Clinical Session on November 28-30 in Las Vegas. This will also meet the objections of those in senior citizens groups and in labor who have pointed out the hardship which the current procedure of requiring a receipted bill has brought about.

Finally, if a physician should object to giving a patient a bill for use in collecting the reimbursable portion, he has the alternative of directly billing the government, which is already allowed under part B.

Needless to say, I am gratified that the AMA has seen fit to support a proposal which would, in some cases at least, cause a delay in payment to doctors.

Unfortunately, the position of the Social Security Administration up to now has been to defend the present procedure. In the standard reply to inquiries on this point, the agency cites a number of reasons for requiring a receipted bill rather than paying the beneficiary without his having paid the bill for the services he has received.

Briefly, these arguments are three:

First, requiring a receipted bill prevents cheating. That is, it prevents a patient from obtaining the services of a physician, collecting the money from the Government, and then using the money for other purposes.

Second, it makes the patient more likely to be concerned about the reasonableness of the physician's charges. According to this reasoning, patients are more likely to be concerned with charges if they must pay the total before they can be reimbursed and know that they will not be reimbursed for any difference between the physician's charge and a reasonable charge.

Third, requiring a receipted bill provides an incentive for physicians to accept assignment. Under this method the physician may not charge the patient more than his customary charge or the charge prevailing in the area.

To my mind, the Social Security Administration reasons for requiring a receipted bill are weak.

It seems to me that an itemized bill would be as effective as a receipted bill in preventing cheating and abuses of medicare. In any case, the problem is the doctor's not the Government's if a patient does not pay for services received. As Mr. Coover of the AMA points out it is a matter of the physician trusting the patient as he has always had to do in the practice of medicine.

If the Social Security Administration really is worried about possible kickbacks or collusion between doctor and patient it matters little whether the Government is presented with an itemized or receipted bill. Both could be manufactured with equal ease.

Second, it seems to me that an itemized bill, more than a receipted bill, will make patients aware of the reasonableness of physicians' charges.

First of all, now many of us have any idea of what is a reasonable charge? Comparison shopping for medical services is virtually unknown. Most of us are accustomed to accepting the bills handed to us by doctors. Our elderly under medicare are no different.

Under the present system if a patient has been overcharged he pays and then is recompensed only in part by the Government. He loses. Where is his anger likely to be directed? Probably the Government as much as the doctor.

Under the procedure which would be established by the Vanik-Zablocki proposal, the patient would have his medical payment in hand and an unpaid bill when he confronts his physician to talk about the charge. It would give the individual a bargaining power in dealing with the doctor which he now lacks.

It seems to me that the real reason for the Social Security Administration preferring a receipted bill is the pressure it puts on doctors to deal directly with the Government and to accept the assignment of charges.

A patient faced with a large medical bill is quite likely to try to convince his doctor to deal directly with the Government.

Such pressures, as we have seen, have been successful in only about half the cases under medicare. Where the incentive has been unsuccessful, moreover, tremendous economic burdens have been put on our old people.

I have no doubt that should our amendment be approved that the percentage of doctors accepting assignment would decrease. However, a sharp drop is to be doubted. Many physicians would prefer to be sure of receiving payment by dealing with the Government rather than take a chance on their patients.

At the same time, however, the change might well have the effect of obtaining greater physician compliance with the Social Security Administration on reasonable rates and charges.

If a patient confronts his doctor with a letter from the Government saying that he has been overcharged and enclosing the fair amount, the physician also will find himself under pressures to accept that sum.

Under the present system, there is no such incentive. By the time that the patient finds out that he has been overcharged the doctor has the money.

Mr. Chairman, I earnestly believe that the reform which this measure would effect is very, very necessary to the smooth and beneficial operation of the medicare program.

The current procedure is punishing our older Americans unnecessarily. It must be changed. It is my hope that this committee will amend the social security laws to reflect the proposal contained in the measure which Representative Vanik and I have introduced.

This concludes my statement, Mr. Chairman.

The CHAIRMAN. Any questions of Congressman Zablocki?

It has been mighty fine of you and I can assure you that the problem you raise and attempt to remedy in your bill and that of Congressman Vanik is under active consideration by the committee.

We recognize the problem that you refer to and if and when we report a bill I hope there will be some relief along the lines that you suggest.

Mr. ZABLOCKI. Again, Mr. Chairman, thank you and your committee for giving me this opportunity to testify. I also want to congratulate the chairman for expediting consideration on this measure.

The CHAIRMAN. Thank you, sir.

We are glad to have you.

Next is our colleague, Mr. Schweiker.

We are glad to have you with us this morning. The Honorable Richard S. Schweiker, a Member of the Congress from Pennsylvania.

Mr. SCHNEEBELI. Mr. Chairman?

The CHAIRMAN. Yes.

Mr. SCHNEEBELI. I also would like to welcome Dick Schweiker to this hearing. He is one of our more promising Congressmen from the State of Pennsylvania and I am sure he has a lot of valuable information to add to this hearing and to our sessions here.

Thank you very much.

The CHAIRMAN. We are glad to have you and you are recognized, sir.

STATEMENT OF HON. RICHARD S. SCHWEIKER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. SCHWEIKER. Thank you, Mr. Chairman, Mr. Schneebeli, and members of the committee. I appreciate this opportunity to testify this morning.

At the outset, let me say I completely support the steps this bill would take to streamline medicare. In the 89th Congress I voted in favor of the original medicare legislation, Public Law 89-97. With

keen interest I have watched this promising program begin in my own State of Pennsylvania. I am convinced that medicare has the potential to provide security for our senior citizens, but we must not neglect the way the program operates in practice.

In this light I wish to report on how bad a start medicare has had in Pennsylvania. Senior citizens in Pennsylvania filing claims for doctor bills have had nightmares of redtape, disillusionment and delays, instead of prompt service. Some men and women who can ill afford to wait have been subjected to 3 months or more delay in being reimbursed for their doctor bills.

My office has received a steady flow of letters, phone calls, and visits from senior citizens complaining bitterly and justifiably about their bad experiences.

Their claims have been tied up for months. Their inquiring letters have been unanswered for weeks. When they have received word on their claims, the replies have been too cryptic to be understood. When payment has finally been made, items of the claim have been rejected without explanation.

Medicare's complexities have imposed burdens on hospital offices as well as on individual patients. A large hospital near Philadelphia with 35 percent of its patients covered by medicare reported to me it has had to add four new clerks to handle additional bookkeeping required by medicare, and it is considering acquiring a costly computer if the situation worsens.

A simplification of the medicare benefit structure as H.R. 5710 proposes will go a long way to eliminate redtape for both patients and hospitals. It would also help rectify the most shocking part of Pennsylvania's experience with medicare. That is the inability thus far of Pennsylvania Blue Shield to keep up with its paperwork as State intermediary for doctor bill claims.

When medicare began, Pennsylvania Blue Shield was woefully unprepared for its job, despite the fact that it had known for 5 months before that it would be a medicare "B" intermediary.

In the first 2 months of medicare, July and August of 1966, a flood of 34,323 claims came in to Blue Shield. Only a trickle of 1,495 paid claims went out, less than 5 percent of the claims received.

By the end of October, Blue Shield had processed only 20.1 percent of the 172,400 claims received by that time.

Despite improved production methods, the growth of the medicare staff to 223 from 94, and the adding of a night shift, Blue Shield had a 6-week backlog of work at the end of January consisting of 180,541 unpaid claims.

Over 35 percent of these unpaid claims were more than 30 days old.

Overall, Blue Shield had paid out only 64.5 percent of the 509,816 claims received from July through January. By the end of January, its monthly production was still 9 percent less than the number of new claims received in a month. This meant the backlog of unpaid claims was continuing to grow.

These shocking figures concerning the processing of medicare B claims account for the widespread delays that senior citizens have experienced. Senior citizens feel that they have been pushed around and trod upon. Aware of the slow payment problem, some 40 per-

cent of the physicians in the State are apparently taking direct payment from medicare patients instead of taking their claims by assignment. This leaves the claim-filing ordeal up to the senior citizen who has already paid his doctor.

Blue Shield, of course, has not had a simple task. In the early months of the program one claim in four had to be sent back to the claimant for more information, a rate that dropped to 8.1 percent in January. New personnel had to be trained and a new computer operation installed.

Claims were burdening the Blue Shield office which, if H.R. 5710's provisions had been in effect, would not have been flowing through medicare B channels.

Thus many causes have contributed to stall the medicare program in Pennsylvania. But at the root of these is the complexity of medicare regulations themselves.

I welcome the provisions of H.R. 5710 designed to bring more order to the medicare benefit structure for hospital inpatient and outpatient care and the physicians' fees which accompany that care.

Up to now hospitals have had to keep three separate records for medicare in their outpatient wards alone. One record was for diagnosis supplied by the hospital, one record was for therapy supplied by the hospital, and the third was for the fees of the radiologists and pathologists attached to the hospital.

Separate records were required because therapy by the hospital was a medicare B item, diagnosis by the hospital was a medicare A item, and the radiologists and pathologists were paid personally out of medicare B.

The irony of this situation is that the typical outpatient bill, for all three kinds of services combined, is so small. Chopping such bills up into three smaller pieces made for complications entirely out of proportion to the gross amount of money involved.

While hospitals wrestled with the three parts of an outpatient bill, patients had their troubles.

Coverage for hospital diagnosis was subject to a \$20 deductible. But coverage for hospital therapy and the doctors' private fees were each subject to a \$50 deductible. If the patient wasn't totally confused at this point in his inquiry, and if he had made his \$20 deductible, he could apply it toward the larger \$50 deductible, too.

H.R. 5710 cuts through this jungle of paperwork when it puts all three types of outpatient care under one medicare plan, B. Now a patient eligible for medicare B doctor bill insurance will be eligible for all three of these outpatient hospital services as well. All these charges will be governed by the same \$50 deductible.

It further simplifies medicare for the hospital inpatient. It extends medicare A hospital insurance to cover all radiologists' and pathologists' services used by the patient admitted to the hospital. These now require separate claims against medicare B, and add to Pennsylvania Blue Shield workload.

And in another main step to simplify medicare, it removes the requirement that a physician formally certify the need for a patient's being hospitalized.

These amendments would make a significant contribution to smoother administration of the medicare program. The situation in

Pennsylvania to date over the processing of medicare B claims, which I outlined earlier, points to the definite need for such streamlining reforms.

Mr. Chairman, I would like to submit, with your approval, for the record, a copy of my January 31 letter to Secretary Gardner concerning the Pennsylvania medicare problem, the reply from Acting Secretary Cohen, together with a comprehensive report on these difficulties from Mr. Ball.

I appreciate very much your having afforded me this opportunity to appear before you.

Thank you.

The CHAIRMAN. Without objection, the additional material you mention will be included in the record at this point.

(The material referred to follows:)

JANUARY 31, 1967.

HON. JOHN W. GARDNER,
Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. SECRETARY. Since the Medicare program went into effect last July, my office has received a steady flow of letters, phone calls, and visits from senior citizens complaining bitterly and justifiably about red tape surrounding their \$3-a-month Supplementary Medical Insurance.

One man was so disgusted he notified Pennsylvania Blue Shield, administrator of the plan in the state, that he was quitting the program. This man actually sent back the benefit check for \$46.40 he had just received. Others have burst into tears in the course of telling their stories. The more outspoken older people have denounced the program to me as a "farce" or as a subterfuge to collect a "\$3-a-month tax" from senior citizens, giving them nothing in return.

I have referred each of these individual cases directly to Commissioner Ball of the Social Security Administration. However, the complaints have reached such a volume and indicate such widespread problems that I have decided to bring the matter to your attention personally.

From what these senior citizens have told me, I think the Supplementary Medical Insurance program needs three improvements:

First, there must be a drastic speedup in claim payments. People in no financial condition to wait long for payments have had to wait three months or more in some cases before their claims were paid.

Second, the complex rules governing the \$50 deductible and the types of services and supplies covered by the insurance must be simplified, to become more comprehensible to people covered by the program.

Third, physicians must be assured that when they accept assignment of a patient's claim, the claim will be paid promptly and with a minimum of paperwork required for the physician. I have been told that some physicians collect their fees directly from patients, who are often hard pressed, rather than wrestle with the complexities of the claim form, SSA-1490.

As for the alleged slowness of payment, I would judge that this is purely a matter of clerical inefficiency and hope steps will be taken promptly to correct it. But the two other kinds of complaints raise deeper questions about Supplementary Medical Insurance itself.

The first stumbling block for many persons over 65, apparently, is establishing that they have indeed spent their first \$50 on medical care. The patient must obtain itemized bills from every physician and supplier whose bills make up the first \$50. Even if the patient succeeds in collecting what he thinks is \$50 worth of itemized bills, the authorities may reject part of that as not within the rules, and the result has been much heartache as well as delay.

In one case brought to my attention, a man submitted a claim for \$232.50 in what he thought were allowable expenses. He received only \$9 back, and without an explanation.

When the authorities have explained their non-allowances of certain expenses, the answer suited the existing rules but was completely at odds with the spirit of the Medicare program. A man claimed \$78 for 13 physical therapy sessions

taken by his wife as prescribed by her physician. He was refused any payment by Pennsylvania Blue Shield. Blue Shield explained that the physical therapist used was not a "home health agency" cooperating with the program under the statute. But neither Blue Cross nor Blue Shield could direct the couple to any agency that was so qualified.

Finally, if the expense is one which the insurance definitely covers, patients are being subjected to the hardship of paying their physicians themselves because the physicians want to avoid paperwork. This happened to an 82-year-old man who had to pay \$675 to the surgeon after a gall bladder operation was performed.

The man's daughter told me that unless the family paid the \$675 they could not obtain from the physicians the documentation they needed to file the claim. The man was released from the hospital October 4. It took over a month for the family to raise the money. On November 11 they submitted their claim, and as of December 15 they had received neither reimbursement nor any acknowledgement of the claim.

In the meantime, the daughter adds, her father has been readmitted to the hospital for prostate surgery and the physicians have again asked for payment in advance of the time the Supplementary Medical Insurance plan would pay.

If these three examples in my Congressional district are typical, then Supplementary Medical Insurance is creating a nightmare of red tape and disillusionment for senior citizens throughout the country. A program which promised so much more security for persons 65 has merely heightened their insecurity over paying their medical bills.

The fact that so many senior citizens have brought their medical insurance problems to me has indicated that they apparently have nowhere else to turn. Whether it is because they are not articulate enough to express their complaints to local authorities or because local offices are unwilling or unequipped to help them, the fact remains that the program has not run well for many of those for whom it was expressly intended. It strikes many as one more failure of an overly-centralized Federal government to serve the people efficiently.

It defeats the very purpose of the Medicare program to make its benefits require a nearly professional knowledge of how to file a claim, as evidenced by the entire page of detailed instructions on the reverse side of Form SSA-1490.

It defeats the very purpose of the Medicare program to make physicians reluctant to take assignments of patients' claims, since this results in making the patient both pay the physician in full after all, and fill out form SSA-1490 himself, and wait.

It defeats the very purpose of the Medicare program to allow claim-paying machinery to operate so slowly that months go by before claims are even acknowledged.

I hope, Mr. Secretary, that you can investigate and move to correct these faults in Supplementary Medical Insurance and I look forward to your reply.

Sincerely,

RICHARD S. SCHWEIKER,
Member of Congress.

* * *

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, February 27, 1967.

HON. RICHARD S. SCHWEIKER,
House of Representatives,
Washington, D.C.

DEAR MR. SCHWEIKER: I very much share the concern expressed in your letter of January 31, 1967, about complaints regarding payments to beneficiaries under the supplementary medical insurance program. I asked Mr. Robert M. Ball, Commissioner of Social Security, for an up-to-date report on the medicare situation in Pennsylvania. The report is enclosed. While neither we nor the Pennsylvania Blue Shield are satisfied at this point with the status of their activity, definite progress has been made in recent weeks and the situation is improving.

You may be assured that there is a distinct awareness among Pennsylvania Blue Shield and Government personnel of the urgency of attaining prompt, satisfactory beneficiary services on all claims. We have been in very close touch with this situation and will continue to render the kinds of help described in this report.

As you may know, H.R. 5710 which was introduced last week contains Administration proposals for simplifying the medicare benefit structure. I am confident that enactment of amendments along the lines proposed would ease administration and lead to better public understanding and improved service to beneficiaries.

Sincerely yours,

WILBUR J. COHEN,
Acting Secretary.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., February 25, 1967.

REPORT ON PROCESSING OF MEDICARE CLAIMS IN PENNSYLVANIA, REPRESENTATIVE
RICHARD S. SCHWEIKER'S INQUIRY DATED JANUARY 31, 1967

MEDICAL INSURANCE (PART B)

In Pennsylvania, physicians' bills, and all claims for payment of physicians' services from individual beneficiaries are the responsibility of Pennsylvania Blue Shield (except Railroad Beneficiaries who are served by the Travelers Insurance Company).

Enclosed is a table containing detailed operational workload information. These data show that, in the first few months of the program, Pennsylvania Blue Shield processed only a small percent of the bills received. In December a more favorable situation began; in that month 109,106 bills were received and 104,575 processed. In January they received 149,967 bills which was the largest number of bills received in any month to date; but at the same time they processed 136,928 bills which is also the largest production achieved so far. Thus, in January, production was the equivalent of about 91 percent of the January receipts. In the month ending January, Pennsylvania Blue Shield had almost 6 weeks work on hand, with 35.8 percent of claims pending over 30 days. During February we expect that production will pull ahead of receipts.

The amount of payments in medical benefits under Part B of the health insurance program has increased each month. As indicated in the table, the carrier paid out only \$54,248.00, in August but in November \$1,215,301.00 was paid. In December the carrier paid \$2,289,422.00, which is practically 100 percent more than was paid in the previous month. The total paid through December was \$4,923,124.00. In January the carrier paid out \$2,591,432.00 under the program.

Delays in claims processing are attributable both to the carrier's need to train new personnel and further develop computer operations for medicare claims, and to the substantial amount of time needed for beneficiaries, physicians, carrier personnel and others to become accustomed to the new program. Also, among the factors that complicate and delay processing are the special provisions that govern billing for radiologists, pathologists and other "hospital-based physicians" as well as the difficulties some beneficiaries have had in securing properly receipted, itemized bills where the physician does not accept assignment.

In order to overcome some of the problems associated with the newness of the program, a new drive on the proper completion of claims has been initiated in all States. We have encouraged beneficiaries, through the press, to take first claims to their local social security district office for assistance in filing and for instructions in the proper completion of forms to facilitate their processing when they reach the carriers. Of course, any beneficiaries who need help in completing these forms or who have any questions at any other time are also encouraged to come to the district offices for help and information. Furthermore, the carriers are using our district officers for help in obtaining needed claims information. Because of more experience and improved procedures, Pennsylvania Blue Shield returned only 8.1 percent of the bills received in January, while in the period July through September, the carrier returned for additional information 25.5 percent of the bills received.

As a result of our mutual consultation toward the end of last year, additional staff are now on duty and the trend of a growing medicare backlog is being overcome. At the beginning of the program, Pennsylvania Blue Shield employed 94 full-time people for medicare work and only a day shift was in effect. Now a night shift is also operating and the total present complement of medicare claims people is 223. Further recruitment is in progress. In addition to the increased

staff, Pennsylvania Blue Shield has leased an additional 10,000 square feet of space to help house the medicare operation. Greater specialization is also being undertaken in various departments to expedite the processing of claims. A procedure for acknowledging the receipt of beneficiary claims which require additional development is also being instituted.

Although you will note that the pending load at the end of January was 180,541 bills, this is not a true reflection of the number of beneficiaries whose claims are awaiting payment. Fifty-three thousand seven hundred (53,700) bills represented claims of hospitals for small charges made for the professional services of radiologists and pathologists whose claims were assigned to the hospital for collection. Forty-five thousand bills are physicians' claims. And, some proportion of the balanced represents a number of bills from the same beneficiary. In any event a part of the current backlog would be a normal pipeline or work processing backlog.

HOSPITAL INSURANCE (PART A)

Payments to hospitals for services to inpatient beneficiaries are flowing smoothly. There were 145,000 medicare admissions reported for beneficiaries in Pennsylvania during the period July-December 1966, and Pennsylvania hospitals were paid \$54,161,000.00 during this period.

Difficulties exist in the area of reimbursement to hospitals for services to outpatients. Although there are not large amounts of money involved for either hospitals or beneficiaries, problems of beneficiary understanding, hospital record keeping and fiscal intermediary administration are caused by complexities in the benefit provisions for outpatient services. Enactment of a legislative proposal to simplify administration of benefits for outpatient diagnostic services and services of certain hospital-based physicians would help relieve these difficulties.

We are aware that the \$50 deductible is a source of some misunderstanding on the part of medicare beneficiaries and that in some cases the problems associated with keeping a record of amounts paid can be significant. These problems are similar to those which have occurred under private major medical insurance policies; they tend to be most severe when a person first enrolls. Our experience already indicates some improvement. The fact that the insurance companies administering these provisions for the program have in a very short time greatly increased their capacity to handle claims indicates that they will increasingly be able to provide beneficiaries and physicians promptly with current information about amounts paid toward the deductible.

Concerning noncovered services, we have made an extended and intensive effort to get the necessary information to beneficiaries in as simple and straightforward a manner as possible. We realize that beneficiaries may, nevertheless, have difficulty in understanding which services are covered. However, the law is quite explicit as to the coverage of services of physical therapists. Under medicare, as under much of private health insurance, the services of privately practicing health practitioners, other than physicians, are generally not covered. In many respects, medicare coverage is broader than much of private health insurance.

In putting the medicare program into effect, we have had the goal that only the minimum paperwork that would meet the needs of the program should be required. We are recommending a change in law to eliminate the requirement for a physician's certification of medicare necessity in case of inpatient and outpatient services in a general hospital. The request-for-payment form for reimbursement of physicians' fees under the medical insurance plan was developed in cooperation with representatives of organized medicine and is very similar to forms currently used by private insurance companies. Our experience to date in Pennsylvania has been that 58 to 60 percent of the claims processed are under the assignment procedure thereby relieving the patient of the need to pay any part of the bill before medicare benefits are paid.

We realize, of course, that in some instances the physician will not accept an assignment even though the beneficiary is not in a position to pay a sizeable fee in advance of medicare reimbursement, and that this can result in real hardship for the beneficiary. As carriers become more current in claims payments and many physicians experience a recognition of their fee as the allowable "reasonable charge" under medicare, we expect the proportion of physicians taking assignment to rise.

ROBERT M. BALL,
Commissioner of Social Security.

Pennsylvania Blue Shield workload data

	Expenditures		Number of claims received	Cumulative number of claims received	Total claims paid	Cumulative number of claims paid	Net increase in claims per month	Cumulative percent of claims paid
	Supplemental medical insurance benefits	Administrative costs						
<i>1966</i>								
July-August (combined).....	\$54,248	\$155,000	34,323	-----	1,495	-----	+32,828	4.3
September.....	403,767	175,000	62,632	96,955	9,471	10,966	+53,161	11.3
October.....	960,386	151,000	75,445	172,400	23,830	34,796	+51,615	20
November.....	1,215,301	135,000	78,343	250,743	52,976	87,712	+25,367	35
December.....	2,289,422	105,000	109,106	359,849	104,575	192,347	+4,531	53.4
<i>1967</i>								
January.....	2,591,432	135,000	149,967	509,816	136,928	329,275	+13,039	64.5
Total.....	7,514,556	856,000	509,816	-----	329,275	-----	+180,541	-----

The CHAIRMAN. Mr. Schweiker, we do appreciate your coming to the committee and discussing this matter with us.

Are there any questions?

Thank you, sir.

Mr. SCHWEIKER. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Meany, we appreciate having you with us, as always. You have been before the committee on many other occasions, but for the purposes of this record, will you again identify yourself.

STATEMENT OF GEORGE MEANY, PRESIDENT, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS; ACCOMPANIED BY ANDREW J. BIEMILLER, DIRECTOR, DEPARTMENT OF LEGISLATION, AND BERT SEIDMAN, DIRECTOR, SOCIAL SECURITY DEPARTMENT

Mr. MEANY. Thank you.

Mr. Chairman, I am George Meany, president of the AFL-CIO and am presenting the views of our organization.

The CHAIRMAN. We are glad to have you, sir, and you are recognized.

Mr. MEANY. We greatly appreciate this opportunity to present the views of the AFL-CIO on H.R. 5710, and on the social security system as a whole.

There is no need to remind you, Mr. Chairman, of the tremendous importance of social security to Americans of all ages.

You have presided over the development of the social security system for many years. The system carries your trademark. And we know that you have always been receptive to proposals to improve social security to broaden it, to make it serve the needs of the American people more adequately—provided these proposals did not endanger the basic soundness of the system as a whole.

It seems to us that H.R. 5710 represents this happy combination. It offers a wide range of badly needed improvements in social security benefits; and it offers a sound and equitable program for financing them.

We can all agree, I think, that the benefit increases are long overdue. We can all agree, as well, on the reason for the delay. Over the last several years, the major objective of those who are deeply interested in social security was its extension to include medicare.

As this committee well knows, that objective was not easily reached. It required deep study, long debate and many refinements of the original proposal before a workable—and generally acceptable—medicare program was evolved.

Now the time has come to return to fundamentals—the basic social security benefits.

President Johnson has made a number of excellent proposals which are incorporated into H.R. 5710. We believe the President's proposals are a long step toward the kind of social security system the American people should have.

This is most apparent when we consider the retirees—the elderly, who depend upon social security pensions for their support.

It is true, and it ought to be emphasized more strongly, that social security is not just an old folks' program. It protects the widows and children of breadwinners who die. It protects the younger worker who is disabled, and those who have depended upon his earnings. These are vitally important safeguards that are too often overlooked, especially by the younger generation of workers, who need them most.

But the great majority of the 22 million Americans now dependent upon social security are elderly retirees. So let us look first at their plight. It is a grim story.

The average monthly social security benefit for a single retired worker is about \$84 a month—about \$20 a week. The average benefit for a retired couple is about \$144 a month or about \$33.50 a week. For 2.5 million widows the average is only about \$74 a month.

The last year workers in this country averaged \$20 a week in wages was in 1936, more than 30 years ago. By 1941, they were up to about \$33.50, the same as a retired couple gets today. But the worker who earned \$33.50 in 1941 could buy more than twice as much for his money as the elderly couple can buy now.

For millions of Americans these benefits, inadequate as they are, spell the difference between grinding poverty and at least subsistence living. Only 25 percent of the aged who now get social security benefits would be above the poverty level without them. In 1965, social security benefits lifted 5½ million, or 38 percent of the aged, out of poverty; but they left 5 million, or 35 percent below the poverty line.

What poverty line am I talking about? I mean the Social Security Administration's definition of poverty. According to that definition, a single worker isn't poor if he has an income of \$1,500 a year. A couple isn't poor if they have \$1,900 a year coming in. It seems to me that this is about as poor as you can get.

Now I understand that this poverty level is based on a Department of Agriculture economy food plan, intended for temporary or emergency use when funds are low. That economy food plan allows 22 cents a meal for each person. Imagine that—22 cents. And since they came up with this figure, living costs have risen over 5 percent. So the social security poverty standard today isn't even enough for a temporary or emergency period. Yet for millions, it is not temporary; it is permanent.

In contrast, the Department of Labor budget for a minimum but adequate living for an elderly retired couple is about \$3,000 a year in a large city and \$2,500 in a smaller one. But even this is pitiful when you see what it provides. For example, it allows only about a half-pound of meat and less than two eggs a day (and that's for two people); three dresses a year (including house dresses) for the wife; the man can replace his topcoat every ninth year. And suppose this old couple want to take in a movie once in a while. According to this generous Department of Labor budget—about a third bigger than social security's version—they can take in a movie just once every 4 weeks.

For another comparison, let's look at the minimum wage. The \$1.40 minimum wage which went into effect last month gives a full-time, year-round worker about \$2,800. Next year he'll get \$3,200 when the minimum goes to \$1.60. Even this year, the worker at the minimum gets nearly three times the average social security benefit of a single retired worker and 60 percent more than a retired couple. Yet he's at the bottom of the scale; less than 15 percent of all workers get no more than the Federal minimum wage.

You can imagine where this leaves the retirees as a group. But there is no need to imagine it. The facts were given in a Social Security Administration study for the year 1962. That was 5 years ago, of course, but there is no reason to believe that any significant improvement has occurred since 1962. Though there was one general increase in benefits since then, it was less than the rise in living costs. Here is what the study showed:

One-seventh of all American families are aged. One-third of all the poor families are aged. For individuals living alone, the figures are worse.

The median income from all sources for aged families—that is, families headed by someone 65 or older—was \$2,895; for aged single persons, \$1,130. This was about half the income of those under 65.

Public sources of income of all kinds amounted to 46 percent of the total income of the aged. Two-thirds of that public income was from social security; the rest was in veterans' benefits, railroad retirement, public assistance and so on.

Earnings accounted for 32 percent of the total income of the aged. But the percentage is deceptive. Half of all the money earned by the aged was paid to a very small group, younger or healthier or better situated, who earned too much to draw social security benefits.

Rent and dividends made up 15 percent of the total income of the aged; private pensions only 3 percent, and other sources 4 percent. This again explodes the notion that the elderly are well fixed, happily equipped with paid-for houses and generous company pensions. Yes, thanks in large part to the labor movement, many millions of American workers are now accumulating pension credits in negotiated plans; but even 15 or 20 years from now, social security will remain the only old-age protection for 70 percent of those who retire.

Therefore, when we discuss the problems and the needs of the aged, we are dealing primarily with social security—the chief, and for the great majority, the only source of retirement income.

Let's review what has happened to that vital source. During the 12 years from 1955 to 1966, inclusive, 90 percent of those who are now

on the social security rolls began to draw their benefits. So when we use these 12 years as a base, we are including practically everyone who is now on the receiving end.

There have been two increases in social security cash benefits over these 12 years. There was a 7½-percent increase in the 1958 and a 7-percent increase in 1965.

But neither of these increases—or both of them together—kept pace with the cost of living, much less the general standard of living. The figures are beyond dispute.

And, of course, we are not concerned just with the purely arithmetical calculation; we are concerned with the broader principle older Americans are entitled to do better than just keep pace with the cost of living in a society where the standard of living is steadily rising. The American standard of living has gone up almost 50 percent since 1954. Surely all of us have an obligation to do more for older people than merely to hold them at a static—and extremely low—level of living. Who is better entitled to share in the increased standard of living than our senior citizens, who did so much to make it possible?

Consider this contrast. Average wages have risen more than 55 percent since December 1954. That average beneficiary I mentioned earlier, with \$66.60 a month in 1954 and \$76 now, would need 36½ percent more, or \$103.76, to keep pace with average wages. The 1959 retiree now receiving \$95.30 would need 18 percent more.

H.R. 31, one of the bills this committee is considering, provides for an increase in social security benefits of only 8 percent. Against the figure I have just given, its inadequacy is appalling.

In contrast, the average 20-percent increase in social security benefits recommended by the President and provided in H.R. 5710 would have real significance. They would enable the elderly and others dependent on social security to begin to share in the fruits of the Nation's economic advance. I said "begin to share," and that's what I mean. The AFL-CIO convention in December 1965, and the AFL-CIO Executive Council last month pointed out that a fully adequate level of social security payments would require a boost of at least 50 percent in present payments. But we regard, and we hope the Congress will regard, the proposed 20-percent increase in benefits this year as a substantial downpayment toward that goal.

We have referred to the erosion of social security benefits by rising prices. We in the AFL-CIO would favor some suitable arrangement for preventing this erosion. We believe that such a provision could be included in the program without any additional financing. The Federal employees retirement system and the military retirement system already contain provisions that adjust benefits automatically in accordance with increases in the Consumer Price Index. We see no reason why social security beneficiaries should receive any less.

Introduction of a cost-of-living mechanism in the social security system would be a forward step, but we would emphasize that this alone does not guarantee adequate benefits. As I noted earlier, social security beneficiaries have a right not just to keep from falling behind in the race with living costs but to participate in the Nation's increased standard of living. Therefore, Congress should give consideration to effective means of keeping social security benefit levels in line with

other incomes. One way to do this would be to provide for periodic adjustment at fairly frequent intervals of benefit levels to some appropriate measure of active workers' earnings.

On the whole, we are most enthusiastic about the proposed increases in minimum benefits. Those at the minimum are the poorest of the poor, and they are therefore a shockingly large group. For example, of the million-plus new social security beneficiaries in 1964, 16 percent were at the minimum. Some 2½ million individuals now receive the minimum of \$44 a month.

Farmworkers, who are among the lowest paid workers in the Nation, make up a large proportion of this minimum benefit group. One-fourth of those drawing minimum primary benefits had some covered earnings from farmwork, either as farm operators or as farmworkers. These are not casual, short-term or part-time workers. Farmworkers receive minimum retirement benefits primarily because they are paid subminimum wages. Incidentally, the provision in H.R. 5710 to cover an additional half million farmworkers would do much to help this group.

Though the purpose of a social security system is broader than the elimination of poverty, it can be used for this purpose to a much greater extent than in the past. Because of the central role of social security in the economic life of our aged population, it can be crucial in lifting the burden of poverty from them. Increasing the minimum benefits as provided in H.R. 5710 would be a major blow against poverty among the aged. We also endorse the higher minimums for those with long histories of contributions, so that the 25-year worker would get no less than \$100 a month.

The increase of at least 15 percent for most beneficiaries would represent considerable progress, but we urge that this be only a first step toward the 50-percent goal I have stated.

As you well know, Mr. Chairman, higher benefits must be paid for, one way or another.

The AFL-CIO has long felt that substantial benefit increases should be partially financed by raising the earnings base on which both contributions and benefits are determined. From the inception of the social security program, contributions have not been paid on all the earnings of workers, but in the early days they were paid on a very large proportion. The original \$3,000 wage base covered 95 percent of all taxable earnings. It is true that Congress has raised the wage base from time to time, but neither fast enough nor far enough. To regain the payroll coverage provided by the \$3,000 earnings base in 1935, the 1967 base should be about \$15,000.

This sounds like a high figure, but it is high only by 1935 standards. If the wage base does not keep up with increased earnings, more and more workers will earn wages considerably above the base—as they do today. More and more can expect maximum social security benefits far below their earnings. Thus a low earnings base not only holds down minimum benefits but also makes maximum benefit payments less and less adequate for persons with middle or high incomes. This lag violates a cardinal principle of the American social insurance system of relating benefits to wages, and thus maintaining, to the greatest possible degree, established preretirement living standards. I might

add that it also weakens the appeal of the social security concept to the younger, well-paid worker.

Failure to raise the wage base also puts a disproportionate burden on low-wage workers. As wages rise and increases in the wage base lag behind these increases, an even smaller proportion of the Nation's payroll is taxed to support the social security system. In the past, the declining proportion of taxable payroll has been partially made up by increased coverage. But social security is now virtually all-inclusive and the possibilities of expanding coverage in the future are extremely limited. If the earnings base remains stationary while incomes continue to rise, tax receipts will be an ever-declining proportion of total income. Higher benefits would require a higher tax rate on a smaller proportion of earnings. Since the tax rate is uniform, low-wage workers bear a greater proportion of the cost. In time, they would inevitably balk at the burden.

H.R. 5710 would increase the wage base in three steps to \$10,800 by 1974. This is a long step toward what we believe is the proper goal—at present income levels—of \$15,000. As stated above, a \$15,000 base today would cover the same proportion of taxable payroll as the \$3,000 base did when the program first began. Moreover, the broader base would provide additional revenue that could be used to increase cash benefits and make possible other desirable improvements.

H.R. 5710 would also raise the contribution rate from 4.4 percent in 1969 to 4.5 percent, and change the present eventual maximum of 4.85 percent to 5 percent—excluding the medicare tax.

AFL-CIO members are properly known for their willingness to pay for what they get, in war and peace. I am completely confident that they will gladly pay their fair share toward a better social security system. Yet, it must be recognized that as we approach the goal of a 50-percent increase in benefits; as we continue to enlarge the scope of the system, a heavier proportion of the tax load will fall upon wage earners.

Frankly, Mr. Chairman, we all realize that because the social security tax is not progressive as to amount of income, it is regressive in the classic sense. We in the AFL-CIO have ridden along with this, over the years, for the sake of the greater objective which we know you share.

But in all candor I think you should know that in time, we shall urge a modest and gradual contribution to the social security trust fund from the general revenues of the United States. We believe this would be an effective way—and a simple one—to introduce the principle of progressive taxation to the social security system. We are not asking for this now, so I will not argue the case for it. But we will be back.

Now let me deal briefly with the proposal to raise the allowable earnings of social security beneficiaries. In one sense we are sympathetic, since those who have unearned income don't have to count it at all. But on balance we are against the idea. If people who can support themselves draw social security benefits, there will be less money for those who can't. What is proposed in H.R. 5710 is no cause for alarm, but we would oppose any drastic rise in the earnings allowance.

Now as to medicare. The AFL-CIO supports the provision in H.R. 5710 for extending medicare coverage to the disabled. All the reasons for providing health insurance coverage for the aged apply equally to those who are disabled. They are a high-cost, high-risk group, living on reduced incomes. At the very time they experience a drastic reduction in income, they are faced with medical and hospital care expenditures far in excess of those confronting the rest of the population. The increase in the earnings base provided in H.R. 5710, which applies to medicare as well as the basic social security contributions, would more than meet the additional cost involved.

There have been many complaints from older workers concerning the financial problems posed by prescription drugs and eye examinations. Reports we get from labor union health centers dealing directly with retired workers have emphasized this. These reports express concern over the large number of the aged who have chronic diseases, requiring the continuous use of expensive prescription drugs which they really cannot afford to buy. The AFL-CIO feels that the cost of these items, so essential to the health of the elderly, should be covered within the medicare program. Therefore we eagerly await the results of the study the President has requested as to how medicare might be extended to cover the cost of prescription drugs. We hope the Congress will act promptly on the findings of this study.

In more immediate terms, H.R. 5710 offers a new part C in the medicare program. It has two main elements. It would embrace in-patient diagnostic radiology and pathology, now covered only under part B of medicare. And it would establish a new hospital outpatient benefit, covering both diagnosis and treatment, substituting for the outpatient diagnosis in the present part A of medicare.

We support both parts of this proposal. The first half corrects a problem we foresaw in 1965—the forced separation of certain normal hospital services from the system of reimbursement. This has caused nothing but trouble for all concerned. The second point would help to remove uncertainty about who pays for what under which section of the law.

Mr. Chairman, I do not pretend to be a technical expert in this area. But it seems to me that a Federal medicare system, to be effective, should be as simple, as straightforward, and as logical as possible. The proposed changes are directed toward this end, and we urge you to approve them.

We also favor the provisions in H.R. 5710 regarding depreciation allowance for determining reasonable cost under both titles XVIII and XIX. We believe this would help to increase the efficiency and reduce the costs of programs under these titles.

Doctors who insist on direct billing are also causing problems for medicare patients. Many retirees are required to raise substantial amounts of money, often thousands of dollars, to pay a doctor so they can have a receipted bill to secure reimbursement. Even though the retiree will eventually be paid in full or in part, the interval causes resentment at best and hardship at worst. We say the direct billing method is wrong and the assignment method should be the sole procedure for paying doctor bills. This would relieve medicare patients of the burden of raising large amounts of cash prior to reimbursement

by the intermediary and would protect them from unreasonably high charges by doctors.

H.R. 5710 is a forward-looking bill which, as I have said, would make substantial improvements in the social security system. But even its enactment will leave gaps that will need to be filled in the near future.

With your permission, Mr. Chairman, I would like to point out some of these gaps and what we believe should be done about them. These suggestions are based upon the overall social security goals set forth in the AFL-CIO convention resolution adopted in November 1965, a copy of which is attached to my testimony. We are by no means abandoning or retreating from these goals, but they are longer term objectives and are not on our agenda at this time.

For instance, our members are increasingly faced with the hardships of enforced early retirement. We understand that more than half the men who apply for social security benefits do so before age 65. This means that their benefits are computed on an actuarially reduced basis, and this reduction is substantial. Early retirees average about \$78 a month compared to \$107 for those who retire at 65. Many older workers are hit by unemployment, automation, and ill health before age 65. Because of their age, health, and the hiring practices of many employers, these workers are unable to obtain work that is related to their skills. But they are ineligible for full retirement benefits because they have not reached retirement age.

Moreover, even though in many cases illness or disability keeps them from getting jobs in their regular line of work, they are ineligible for disability benefits because theoretically they can still do some sort of gainful work, even though no one is actually likely to hire them.

We believe a flexible zone of retirement between 60 and 65 could be incorporated in the social security law—one that would permit retirement at age 60 with less than full actuarial reduction, and would allow older workers to draw disability benefits if their disability prevents them from doing their usual work—provided, of course, such changes were accompanied by a substantial increase in benefits.

We would also like to see improvements in the basic disability insurance provisions. Disability benefits are not paid unless total disability last 6 months and only if the disability is expected to result in death or last for a continuous period of not less than 12 months. This long waiting period means that large numbers of workers, though disabled for extended periods of time, are without either earnings or benefits just at the time when their expenses are highest. The disability provisions should be changed to allow benefits after a shorter period of total disability—as a first step, 3 months, but eventually, 1 month—and without regard to the expected duration of the disability.

We realize that these additional improvements are not within reach during this session, and—like a fully adequate improvement in benefits levels—some may have to wait on general revenue financing. But we urge Congress to look upon any legislative changes this year as only the beginning of a systematic, planned program to improve the social security program. This year's gains should be regarded only as a downpayment toward a much better social security system in the

future. In the meantime, enactment of H.R. 5710 would be an excellent start.

Now let us turn to a related field, also covered in H.R. 5710—public welfare.

The legislative record of the last few years will live as a shining example for future generations. The social progress—the wide-ranging attack on longstanding abuses—has no equal in the Nation's history. Yet I think it is very likely, Mr. Chairman, that this era will be remembered best for publicly and officially recognizing the fact of poverty, and expressing the national will to wipe it out.

But having said this, we find it all the more difficult to understand why some of those who readily acknowledge the existence of poverty would nevertheless slash the very programs which bring help to the poor. Rather than curtail public welfare, we should be extending and improving it, for public welfare programs now reach only a small fraction of the poor and helps even that fraction inadequately.

Unfortunately, public welfare is a favorite target of some State and local politicians. We hear outcries about "mounting costs," and so-called abuses. Yet—while it is true that the dollar cost of public assistance has risen, the relative cost has held steady or actually declined.

In the 1960-65 period, for instance, the gross national product rose 46 percent; public assistance costs went up 34 percent. Population increased 8 percent; public assistance recipients showed the same increase. Per capita disposable income jumped 24 percent; public assistance payments per recipient went up 17 percent—from \$600 a year, or \$11.54 a week, to \$702, or \$13.50 a week.

The dollar cost of public assistance has risen for other reasons besides population growth. To start with, there have been larger than average increases in the numbers of the young and the old, the two most dependent groups in our society.

Inadequate social security benefits—lagging behind living costs—have forced more social security beneficiaries to seek public assistance.

Guidance, training, and rehabilitation programs for those on public assistance—and job opportunities for them, too—fall far short of the need. But this is less important than it might appear. Most people receiving public assistance, including large numbers of the elderly, the disabled and mothers with young children, could not or should not work full time anyway, even if jobs were available.

While in absolute terms the number of people receiving public assistance has been slowly rising, the fact remains that most poor people—78 percent, in fact—get no public assistance whatever. And again I am referring to those who are "poor" by the Social Security Administration's definition, which, to me sounds more like destitution.

The main reason why so few people—only 22 percent—get public assistance is that less than half of the poor fall into the four narrow, artificial categories that now prevail: the needy aged, the blind, the permanently and totally disabled and certain needy families with dependent children. These are the categories for which Federal matching grants for public assistance are available. In addition some, but not all, States finance general assistance programs for which there are no Federal matching grants.

Besides the limited categories, there are other reasons why public assistance helps only a small fraction of the poor. Some States lack the money—or the will—to participate in all the available Federal programs. Some States impose limitations and restrictions not required by Federal law. And assistance standards in some States are so low that they exclude many persons who are below the State's own minimum needs standard and far below the poverty level—any sort of poverty level.

Because of these gaps, here are some of the people who—in some States—get no help from federally aided public assistance:

Most needy adults under age 65 who are unemployed or unable to earn an adequate income.

Most needy children living with both parents.

Needy disabled adults who are not both permanently and totally disabled.

Many children in need because of the unemployment of the family wage earner.

Needy persons who have not lived in a State for a specified period.

Needy employable mothers for whom no jobs are available.

Needy persons with defective vision but not blind enough to qualify for assistance.

The particular groups deprived of assistance vary from State to State, since eligibility is determined by the States.

Now let's look at the "lucky" ones, who do get public assistance. Here are the average monthly cash payments for the country as a whole in September 1966:

Old-age assistance-----	\$66. 83
Aid to the blind-----	86. 11
Aid to the permanently and totally disabled-----	7. 76
Aid to families with dependent children (per person)-----	35. 63
General assistance-----	37. 93

These are averages. In Mississippi payments to families with dependent children averaged \$7.92. In New York—the leader—the average was \$57.92.

These payments are so terribly inadequate because most States do not meet their own needs standards in fixing public assistance benefits. For example, the maximum benefit to families with dependent children, as of January 1965, was less than the State's own minimum needs standard in all but 19 States. Mississippi paid a maximum amount which was only 28.5 percent of its own estimate of rockbottom needs.

A program for correcting these shocking deficiencies has already been drawn up. The Social Security Amendments of 1962 called on the Secretary of Health, Education, and Welfare to appoint an Advisory Council on Public Welfare to review the public assistance and child welfare programs and to report its findings and recommendations to the Secretary. The Advisory Council submitted its report on June 29, 1966. It bore the title, "Having the Power, We Have the Duty." The words are from a speech by President Johnson in 1964 in which he said: "Today, for the first time in history, we have the power to strike away the barriers to full participation in our society. Having the power, we have the duty."

In its report, the Advisory Council recommended a new approach to the Nation's public welfare programs, the main features of which are these:

(1) A national minimum standard for public assistance payments below which no State may fall.

(2) A nationwide comprehensive program of public assistance based upon a single criterion: Need.

(3) A uniform, simple plan for Federal-State sharing in the costs of all public welfare programs requiring equitable and reasonable fiscal effort by the States, and recognizing the relative fiscal capacity of the Federal and State Governments.

(4) Comprehensive social services readily accessible, as a right, at all times to all who need them.

(5) The administration of all welfare programs receiving Federal funds in accordance with the principle of public welfare as a right.

The AFL-CIO supports these recommendations. We recognize that to achieve them would require substantially more funds than are being spent today on public welfare. We are aware that some of these objectives can be reached more quickly and more readily than others. But it is in the framework of these ultimate objectives that we offer our recommendations with respect to the legislation this committee is considering.

The President has recommended, and H.R. 5710 requires, the States to raise cash payment to welfare recipients to the level the State itself sets as the minimum for subsistence; and it requires the States to bring these minimum standards up to date annually. We endorse this proposal.

We also support the bill's extension of aid to families with dependent children. I am referring, of course, Mr. Chairman, to that aspect of the program which covers aid to dependent children of unemployed parents. But we strongly urge that this program, now voluntary with the States, be made mandatory, and that the so-called man-in-the-house rule be immediately eliminated wherever it is in effect.

Furthermore, assistance should not be denied to needy mothers of dependent children because they are presumed to be employable.

These changes would not only help needy families to meet minimum subsistence needs, but they would also stem the tide of family disintegration resulting from cruel and arbitrary rules which often govern eligibility for public assistance.

Adult recipients of these family benefits often lose welfare payments dollar for dollar, because of the money they earn when they are able to find work. This is a senseless penalty which destroys employment incentives. As H.R. 5710 recognizes, earnings should be permitted up to some reasonable amount before welfare payments are reduced.

We warmly support the provision in H.R. 5710 for temporary assistance to migratory workers and to others who come into a State seeking employment, who are ineligible for public assistance because of State residence requirements.

Other improvements are needed. Minimum standards should be required in housing occupied by public welfare recipients, the rents

of which are paid from public funds. Public welfare should stop subsidizing slum housing.

Aid to the permanently and totally disabled should be extended to the relatively short term disabled, recognizing partial disability which is seriously incapacitating and eliminating the present minimum age of 18.

Detailed investigations of public assistance applicants and recipients are essentially demeaning. They should be replaced by less costly and more democratic methods of determining eligibility. These should be consistent with constitutional and statutory rights, and should not violate the privacy or dignity of individuals seeking assistance.

Child welfare programs should be extended and improved. Better services are needed for the care and protection of children, including foster care, day care, and institutional services.

The next category of H.R. 5710 that I will cover is medicaid, title XIX of the act.

This title was one of the major accomplishments of the 89th Congress. It envisions a bold attack on illness, disability, and premature death among the low-income families of America. Section 1903(e) states:

The Secretary (of HEW) shall not make payments under the preceding provisions of this section to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain independence or self-care.

The intent of the legislation is clear. It would make comprehensive health services—covering prevention and cure of disease, plus rehabilitation—available to all the American people, including those whose income is too low for them to pay the cost with their own money. Mr. Chairman, this is not just a noble and idealistic proposition. It is very practical. For it attacks the severe but little-known failures of medical care today. Let me cite a few of them:

1. By any objective standard the United States—rich in both money and medical talent—should be expected to have the lowest infant mortality rate in the world. But in fact, the relative rank of the United States among the nations of the world is low and has been falling. In 1950, the United States ranked sixth among the nations with a rate of 29.2 infant deaths per 1,000 live births. In 1960, while the rate had improved to 26 deaths per 1,000 live births, the United States fell to 11th place. By 1964, the United States ranked 14th.

2. Untreated glaucoma and diabetes are the second and third leading causes of blindness in the United States:

3. About 300,000 Americans die of cancer each year. A substantial proportion of them could be saved if cancer was detected early.

4. Twenty-nine percent of the young men called by the draft in 1965 failed either their preinduction or postinduction physical test.

5. The annual economic cost of illness—the direct expenditures for medical care plus the indirect cost of illness disability and death—

amounted to \$93 billion in 1963, according to the Social Security Administration.

Much of this reflects inadequate health care, especially for low-income groups. All of it suggests that attacks on the cost of the title XIX program are irrelevant. In view of the tremendous losses, of all kinds, caused by illness and by premature death, the more relevant question is whether we can afford not to implement title XIX with a broad scope of benefits, adequate in duration and extending to the needy and the medically needy who could not otherwise afford them.

I repeat, this is not just a humanitarian undertaking. From every point of view, by every measure, the whole Nation stands to lose from preventable illness, disability, and premature death.

Let me return to the relative decline in the rank of the United States in infant mortality rates. This must surely move the coldest heart. These babies do not die because the quality of medical practice in this country is inferior. The training of our physicians compares favorably with that of any country in the world. Our aids to diagnosis and treatment are, indeed, the envy of the world. Then what is wrong? Most authorities agree that people with low incomes are just not receiving the medical care they need. Low-income people simply cannot afford it.

It is significant that all of the 13 countries whose infant mortality rates are lower than ours have a system of providing or of financing health care for the great majority of their population. Their lower infant mortality rates indicate that access to medical care is more important than the medical competence of the practitioners.

There are other barriers, of course, to adequate medical care. Entry into the complex of medical services is very difficult for the nonpaying patient. He is subjected to long waits and inconsiderate attention in the out-patient clinic of general hospitals. For most poor people the much vaunted doctor-patient relationship just does not exist. If a patient sees the same doctor twice at the clinic, it is a mere coincidence. No one takes a continuing responsibility for coordinating the health services necessary for the recovery of the patient. The poor person receives episodic, uncoordinated, and fragmented care.

Title XIX reflects real statesmanship in that it not only could remove the economic barriers to high quality medical care, but would also attack the problems of fragmentation. We refer to section 1902 (a) (22) (D) which calls for State plans to adopt standards and methods "to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality." In short, title XIX holds the promise of eliminating the double standard of health care which we now have in this country, namely: one standard for poor people and another for those who can afford to pay.

In 1964, private consumer expenditures for health services averaged \$131.18 per person or almost 6 percent of per capita disposable income. Since 1964 the cost of medical care has increased more than 10 percent so that today the average per capita consumer expenditure for medical care exceeds \$144.

It should be emphasized that this figure represents an average of what people are actually paying for medical care, and not what they ought to be paying—or would be paying—for all the care they really

need. It should be emphasized, also, that the need for medical care is greatest among the poor, and because of that, they should be spending substantially more than the national average.

However, let us take the minimum figure of \$144 per person per year. On this basis a family of four should be spending \$576 per year for medical care. At the poverty level of \$3,100 for a family of four, a family could not afford to spend anything like this. It would be 19 percent of their income. Even for the family of four with a \$6,000 income, \$576 would be nearly 10 percent of that income.

It is clear that lower income families cannot and do not pay for the medical care they need. Instead of reducing the Federal commitment to the States, we feel the commitment should, if anything, be increased.

Therefore we welcome the President's proposals on title XIX, which include—

- (1) An increase of \$100 million in Federal financial participation for needy children.

- (2) A requirement that States provide periodic health examinations for needy infants and children as well as treatment for defects discovered.

- (3) Establishment of a citizens' advisory committee to the Welfare Administration with a majority of its members representing consumers of medical care.

We also propose these further improvements:

A requirement that all States include all medically needy children under 21 in their title XIX programs.

An increase in Federal participation under title XIX for the poorer States from the present maximum of 83 percent to a minimum of 90 percent.

Federal participation in all programs for the medically needy between the ages of 21 and 64. At the very minimum, Federal financial participation should be made available under title XIX for those persons receiving cash assistance under the various State general assistance programs.

Better coordination between titles XVIII and XIX.

Equalized Federal participation for professional services regardless of State administrative arrangements.

This brings me to the few provisions of H.R. 5710 which we oppose.

We are deeply opposed to setting an income ceiling, under title XIX, of only 50 percent more than the ceiling for cash benefit public assistance programs. I have already noted that the cash benefits are scandalously low. Tying title XIX to this kind of formula will deprive large numbers of people from the medical care they need.

We also are resolutely opposed to title XIX amendments that would eliminate Federal matching for the medically needy between 21 and 65; that would impose new limits on the amount or proportion of Federal participation, since Federal standards should set minimums, not maximums; that would allow differences in benefits based on age or other categories, or that would permit the States, directly or indirectly to use title XIX to escape part of their own obligation.

Let me turn to a paradox in America—medical miracles are saving lives on the one hand and on the other hand there is a decline in the

relative standing of the United States in regard to infant mortality rates. This poses a major challenge to the most affluent country in the world. The greatest and most productive investment that we, as a nation, can make is in the future health and social well-being of our future citizens. President Johnson has proposed a 12-point comprehensive program for the children and youth of America. Among these proposals are five relating to child health that are contained in H.R. 5710. These include new or additional Federal funds for—

- (1) Early casefinding and treatment of handicapping conditions of children.

- (2) A new national dental health program for children.

- (3) Increased authorization for special maternity and infant care projects with emphasis on infant mortality.

- (4) Increased authorization for training of personnel for health care and related services for mothers and children.

- (5) Increase of the maximum authorization for research with special emphasis on efficient utilization of health manpower.

Poor families simply do not have enough money for the health care they need. We can no longer tolerate a situation where good health is a luxury to be enjoyed only by those who can afford it.

Six out of every ten children from low-income families who are afflicted with one or more chronic health conditions are not receiving treatment. In the Headstart program of the Office of Economy Opportunity only 62 percent of the children found to have an allergy condition were previously known to have such a condition. Of those with skin disorders, only 36 percent were known. Of those with vision defects, only 24 percent were known. Of those orthopedic defects, only 29 percent were known. Of those retarded, only 37 percent were known. Of those with speech or hearing disorders, only 22 percent were known.

The problem is even more acute in dental care. Only the relatively well to do receive adequate dental services. In fact, only one-tenth of the population account for about two-thirds of all visits to the dentist. Among poor children, 65 percent have never seen a dentist and they have five times as many decayed teeth as do children from more affluent families. The result is that for low-income families extractions account for 37 percent of all visits to the dentist compared to only 10 percent of all visits for upper-income families. We have more than a current problem. We face accumulated dental neglect of massive proportions. According to the Public Health Service, about \$3 billion now is being spent annually for dental care. Based on the accumulated need for dental care, the annual total cost for dental treatment might be in the range of \$20 to \$25 billion for the first year if all individuals requiring treatment were to receive it.

We have moved too slowly toward the goal of making the next generation a more healthy and productive one, particularly in the field of dental health. We believe Congress should authorize the amounts provided in H.R. 5710 for child health as the absolute minimum required.

Finally, Mr. Chairman, let me include in the record these paragraphs from the AFL-CIO Executive Council statement adopted on February 20:

The general objectives of the President's proposals for revision of the tax structure for the elderly are based on the fact that the present structure is both unduly complex and lacking in equity.

However, we find one major fault in the particular mechanism the Administration has proposed for achieving these objectives. We particularly oppose the aspects of the Administration's recommendations which involve taxation of Social Security and Railroad Retirement benefits.

Social Security payments under federal programs have always been tax-exempt while the incomes on which contributions to the social insurance funds have been based have been subject to tax. This should continue to be guiding principle.

Mr. Chairman, this has been a long presentation. I appreciate your patience, and that of the committee, for hearing me out.

We in the AFL-CIO deeply appreciate the many courtesies and the great consideration we have been afforded, over the years, by this and other committees of the Congress. We have tried to do our part by presenting our views as briefly as possible.

If I took an unusual amount of your time today, it is because the matter at issue is both complex and important.

Social security, in the broadest sense, represents the striving of mankind for a better world; a world in which old age is a promise instead of a peril, in which illness or premature death are personal tragedies rather than family catastrophes.

There is a long way to go before this Nation, much less the world, reaches these goals, and the bill before you falls far short of them.

Yet the goals are important. They are important because if we stop striving for them, if we settle for a comfortable version of things as they are, the American spirit will be dead indeed.

I know it is not dead, and, Mr. Chairman, so do you.

Thank you.

With your permission, I would like to place into the record at this time the attachments to my prepared statement.

The CHAIRMAN. Without objection, the attachments to Mr. Meany's prepared testimony will be included in the record at this point.

(The material referred to follows:)

STATEMENT BY THE AFL-CIO EXECUTIVE COUNCIL ON SOCIAL SECURITY AND WELFARE, FEBRUARY 20, 1967, BAL HARBOUR, FLA.

The AFL-CIO strongly supports the President's recommendation for an overall 20 percent increase in Social Security benefits. The President's proposal would have the immediate effect of increasing benefits for all present and future recipients and pulling 1½ million poor now receiving Social Security benefits out of the mire of poverty. It also includes a number of other significant improvements in the Social Security program.

On the other hand, the Republican proposal for a mere 8 percent increase in Social Security benefits is grossly inadequate. While it has the surface attraction of avoiding increased contributions, benefit levels would still be so low that very few beneficiaries now below the poverty level would be raised above it.

We consider the President's proposal as a significant down payment on the needed 50 percent rise in benefits and other improvements in Social Security, including disability insurance and medicare, called for by the last AFL-CIO convention. Such further improvements should be achieved as soon as possible. The 50 percent goal would require some financing from general revenues which we believe is necessary and desirable. But we believe the President's proposal represents a substantial first step toward that goal, which can be enacted now without imposing a burden on the general revenue.

In addition to the improvements recommended by the President, we believe that the legislation should also provide that both benefit levels and the earnings base on which both contributions and benefits are determined should be kept up-to-date by periodic adjustment, keeping them in line with the incomes of those still working. In this way the elderly and other Americans dependent on Social Security will be able to share in the nation's economic progress.

We endorse the President's recommendation to extend medicare to the disabled. While we favor the eventual extension of medicare to all Social Security beneficiaries, the disabled clearly deserve special priority as a group burdened by unusually high medical costs at a time when they can least afford them.

The AFL-CIO unreservedly rejects the vicious campaign of false charges aimed at slashing public welfare programs throughout the country. To the contrary, we insist that public welfare must be extended and improved to adequately meet the minimum needs of those among the poor who are either ineligible for Social Security or whose Social Security payments are too low to meet even rock-bottom minimum requirements.

To this end we endorse the recommendations of the Advisory Council on Public Welfare for an expanded national effort and a new pattern of federal-state cooperation to provide as a matter of right adequate financial aid and social services to all in need. Until such time as an adequate national standard of need can be established for public assistance, we strongly support the President's recommendation that in their public assistance payments states be required to meet their own definition of need which should be kept up-to-date annually as conditions change. We urge elimination of the outmoded and unjust categorical approach so that welfare payments would be based on the only appropriate test, need. We especially urge federal action to abolish the "man in the house" rule and other senseless and cruel penalties imposed on needy families in some areas which are a blot on American traditions of compassion and social justice.

The general objectives of the President's proposals for revision of the tax structure for the elderly are based on the fact that the present structure is both unduly complex and lacking in equity.

However, we find one major fault in the particular mechanism the Administration has proposed for achieving these objectives. We particularly oppose the aspects of the Administration's recommendations which involve taxation of Social Security and Railroad Retirement benefits.

Social Security payments under federal programs have always been tax-exempt while the incomes on which contributions to the social insurance funds have been based have been subject to tax. This should continue to be the guiding principle.

BACKGROUND STATEMENT ON SOCIAL SECURITY AND WELFARE BY AFL-CIO DEPARTMENT OF SOCIAL SECURITY

SOCIAL SECURITY

The Social Security Act of 1935 provided for a Federal system of old-age retirement insurance for American wage earners. Though originally limited in scope, to old-age retirement, the program has greatly expanded over the years until now it covers about 9 out of 10 wage earners and provides protection against other contingencies such as death, disability and health insurance after 65.

In September 1966 there were nearly 22 million Social Security beneficiaries of whom slightly more than half (11½ million) were retired workers aged 62 and over, and slightly less than half (10½ million) dependents, survivors and disabled. All the more than 1 million receiving disability payments and nearly 5 million dependents and survivors were under age 65. In addition, Medicare covers nearly all of the 19 million aged 65 and over.

Inadequacy of present benefit levels

Some 37 percent of all Social Security beneficiaries receive incomes, including the little they get from non-social Security sources, below the Social Security Administration's definition of poverty—\$1,500 for an individual, \$1,900 for a couple and graduated higher amounts for larger families. Most of the poor beneficiaries are elderly (age 62 and over) but about 1½ million are not.

The Social Security Administration poverty standards are extremely strict. They are based on a Department of Agriculture "economy food plan," amounting to only 75-80 percent of a basic low-cost plan, intended for "temporary or emergency use when funds are low." In a 4-person family, it allows only 22¢ a meal per person. Moreover, living costs have risen over 5 percent since the SSA poverty standard was developed. Therefore, the SSA poverty definition must be considered well below even subsistence levels if it applies, as in the case of nearly all Social Security beneficiaries, to longer than a "temporary or emergency" period.

Yet average Social Security benefits do not provide even this sub-minimum level of living. On a monthly basis, the Social Security poverty standard is \$125 for a single person and about \$154 for a couple. In September 1966 the average monthly Social Security benefit was \$84 for a retired worker, \$74 for a widow and \$98 for a disabled worker. For a retired couple it was \$142. Thus, Social Security benefits in every major category are at sub-poverty levels even according to SSA's exceedingly stringent standards.

Another appropriate standard of comparison is the minimum earnings workers receive while still employed. The present Federal minimum wage of \$1.40 an hour allows a full-time worker (2,000 hours per year) \$2,800.¹ This is nearly three times the average Social Security benefit of a single retired worker, more than twice as high as for a disabled beneficiary and more than 60 percent higher than a retired couple receives under Social Security.

At such low levels, workers retiring on Social Security receive only a fraction of their pre-retirement earnings—45 percent for a couple and only 30 percent for a single worker.

Contrary to popular belief, the overwhelming majority of the aged retiring today (85 percent) are not covered by other retirement systems. Even in fifteen to twenty years, Social Security will be the only retirement system for 70 percent of the retired population.

The President's proposals

The major features of the President's proposals are:

- (1) An over-all average 20 percent increase in benefit payments.
- (2) An increase of 59 percent for the 2.5 million receiving the minimum benefit.
 - From \$44 to \$70 for an individual.
 - From \$66 to \$105 for a couple.
- (3) An increase of at least 15 percent for the remaining 20.5 million beneficiaries
- (4) For those with 25 years of coverage a minimum benefit of \$100 for an individual and \$150 for a couple.

The comparatively large percentage rise in minimum benefits will provide much-needed help to many people in particularly dire straits. It is estimated that of the \$4.3 billion additional benefits payable under the Administration's proposals in the first 12 months, close to two-fifths will go to poor and about half to poor and near poor beneficiaries.² Some 29 percent of all beneficiaries, including 33 percent of those 65 and over, will be moved out of poverty.

While it is true that many women, including large numbers living alone, receive minimum benefits, so do a considerable number of men. Men constitute $\frac{1}{3}$ of minimum benefit recipients and even a larger proportion of those receiving benefit amounts considerably below average (\$45-\$64). Although more than 4/5 of minimum beneficiaries are white, Negroes are more than twice as likely as whites to receive such a low benefit. Farm workers and domestic employees also constitute a large proportion of the minimum benefit group.

The President's proposal will substantially improve benefit payments of those at or near the minimum, but they will also have a considerable impact at higher levels. This is not only because all benefits will go up at least 15 percent but also because benefit levels are based in part on the earnings base which will rise to \$7,800 in 1968, \$9,000 in 1970 and \$10,800 in 1974. Even if there were no further increases in benefits after this year's changes are made, workers at higher earnings levels (\$7,800 to \$10,800) could eventually get retirement benefits 24 to 62 percent higher than under the present law. Ultimate benefits for survivors and the disabled will also rise very significantly.

The AFL-CIO regards the President's proposal as a significant down-payment on the 50 percent rise in benefits and other improvements in Social Security, including Disability Insurance and Medicare, which the last Convention of the AFL-CIO called for. The Convention resolution asked that Social Security benefits be increased at least 50 percent in several steps over the next few years. The Convention also made a number of recommendations for greater flexibility in

¹ Next year this figure will go up to \$3,000 based on the scheduled \$1.60 minimum wage. The AFL-CIO supports a minimum wage of \$2, which would give the full-time worker \$4,000 a year.

² Poor defined as less than \$1,500 for an individual and less than \$1,900 for a couple. Near poor defined as less than \$1,800 for an individual and less than \$2,600 for a couple.

the OASDI system permitting older workers more rational retirement choices as well as improvements in Medicare to further reduce medical costs for the elderly.

Achievement of a 50 percent increase in benefits and some of the other needed improvements in Social Security cannot and should not be financed entirely by employer and employee contributions. They would require some financing from general revenues which we regard as both necessary and desirable. But enactment of the President's proposal would represent significant progress toward the 50 percent goal which can be accomplished now without financing from general revenues.

Medicare for the disabled

The justice of the President's most important Medicare proposal, inclusion of disabled persons under age 65, cannot be disputed. Like the elderly they are a group with both reduced incomes and much higher than average medical costs. They, therefore, deserve priority in any coverage extension under Medicare. Since the earnings base for contributions will rise for Medicare as well as OASDI, this will provide additional revenue more than enough to pay for the increased costs incurred by extending coverage to the disabled.

Paying for the proposed improvements

In 1968, the first full year, the total cost of the President's recommended improvements is estimated at about \$4.5 billion. Except for a very small increase in the contribution rate over already scheduled changes (0.1 percent in 1969 and 0.15 percent total by 1974), the major change in financing is an increase in the earnings base in steps from \$6,600 a year now to \$10,800 in 1974.

Of the total increase in cost, approximately half will be met by the favorable actuarial balance in the Social Security Trust Fund. The rest of the cost is split— $\frac{2}{3}$ from the higher earnings base and $\frac{1}{3}$ from the slightly increased contribution rate.

The AFL-CIO considers the increase in the contribution rate minimal and necessary. We consider the increase in the earnings base not only necessary but fair and desirable. Failure to raise the wage base not only puts a disproportionate burden on low wage workers but it also puts an unduly low ceiling on the benefits of higher wage workers. This is because the earnings base helps to determine not just the contributions but also benefits.

The President's proposal for increasing the earnings base to \$10,800 by 1974 is, if anything, too modest. If the wage base were to cover the same percentage of payroll as the \$3,000 base in 1935, it would have to be \$15,000 today and even higher in later years.

Periodic adjustment

Once benefit levels and the earnings base have been raised, they should be kept up-to-date by an effective adjustment mechanism. It has been proposed that this should be done by tying benefit levels to the cost of living. The AFL-CIO regards this as insufficient because if Social Security benefits no more than keep pace with living costs, people dependent on Social Security for their incomes will be barred from sharing in the fruits of economic progress. Therefore, Social Security benefits, as well as the earnings base, should be periodically adjusted in lines with the movement of the wages of workers still on the job.

The Republican proposal

The Republicans have proposed a mere 8 percent increase supplemented by an arrangement which with considerable lag would adjust Social Security benefits to the cost of living. Their proposal contains no new financing provisions because the minimal increase it provides can be completely met by the actuarial surplus now in the Social Security Trust Fund.

Despite this apparent attraction, this is a completely inadequate proposal. The 8 percent increase in benefits would still mean that average benefits for both elderly individuals and elderly couples would be below the poverty level. The minimum benefit for a single person would be only \$48—or \$576 a year, about $\frac{1}{3}$ of the SSA poverty standard, which, as indicated above, is exceedingly strict.

Thus, low wage earners would continue to draw extremely low benefits. The proposal would also miserably fail to help higher wage earners. This is not only because of the very small percentage increase in benefits but also because the Republican proposal would do nothing to increase the earnings base, thereby preventing any substantial increase in benefits for workers at higher earnings levels.

The cost of living arrangement gives the false impression that benefits would henceforth be maintained at adequate levels. Actually, it would only permit Social Security beneficiaries to keep pace with the buying power of the unduly low benefits the Republican proposal would provide. What is needed instead is a much larger increase in benefits and assurance that Social Security beneficiaries would keep pace not only with the cost of living but with increase in the standard of living the rest of the population enjoys.

WELFARE

Less than $\frac{1}{4}$ of the poor in America receive public assistance. Nowhere do public welfare payments bring the incomes of the poor who receive them even up to poverty levels. Public welfare programs throughout the country are so financially starved of needed funds that they can provide only sub-minimum maintenance and inadequate social services to a mere 22 percent of the poorest and most underprivileged members of our society, including mothers caring for fatherless children, the poorest among the elderly and the needy disabled and blind. These stark facts measure the inadequacy of public welfare but they do not tell the whole story. Here are some additional reasons why there is an urgent need for significant improvement and modernization of public welfare programs:

1. Contrary to the allegations of those who would slash public welfare programs, most needy people get no public assistance whatsoever. The main reason is that less than $\frac{1}{2}$ of the poor fall into the artificial categories of public assistance we have established: the needy aged, the blind, the permanently and totally disabled, and certain needy, families with dependent children. In addition, some, but not all, States finance general assistance programs for which there is no Federal aid. So few poor people get assistance because:

There are gaps in the categories of needy people for whom Federally-aided public assistance is available.

Some States are either financially unable or unwilling to participate in all the available Federal programs.

Some States provide limitations and restrictions not required by Federal law.

Assistance standards in some States are so low as to exclude many persons who are below the State's own minimum need standard and far below the poverty level.

Because many of the poor do not fit into restrictive categories, among the poor who get no help from Federally-aided public assistance programs are:

(a) Most needy adults under age 65 who are unemployed or unable to earn an adequate income.

(b) Most needy children living with both parents.

(c) Needy disabled adults who are not both permanently and totally disabled.

(d) Many children in need because of the unemployment of a parent.

(e) Needy persons who have not lived in a State for a specified period.

(f) Needy employable mothers for whom no jobs are available.

(g) Persons with defective vision but not blind enough to qualify for assistance.

2. Public assistance payments are extremely low and everywhere below poverty levels. Average monthly cash payments in September 1966 were:

Old-age assistance.....	\$66.83
Aid to the blind.....	86.11
Aid to the permanently and totally disabled.....	71.76
Aid to families with dependent children (per recipient).....	37.93
General assistance.....	37.93

These were averages. In Mississippi, the average AFDC payment was \$7.92 while the highest, New York was \$57.92.

3. Most States do not meet their own needs standards in public assistance. For example, the highest amount paid to AFDC families in January 1965 was less than the State's own minimum needs standard in all but 19 States. Mississippi paid a maximum amount which was only 28.5 percent of its own estimate of rock-bottom needs.

Why have public assistance costs increased?

Although the inadequacy of public assistance cannot be challenged, its cost is nevertheless increasing. However, this is true only in absolute terms, for public assistance costs are declining as a proportion of GNP.

The increase in dollar public assistance costs can be attributed to:

(1) Rising though still inadequate payments which in most cases have not even kept up with living costs.

(2) Larger than average increases in the number of young and the old, the two most dependent groups in our society.

(3) Inadequate Social Security benefits which have forced a considerable number of people on Social Security to seek public assistance to meet minimum needs.

(4) Inadequate guidance, training and rehabilitation programs and insufficient work opportunities to permit ultimately employable public assistance recipients to obtain the jobs they might fill. It should be recognized, however, that most people receiving public assistance, including large numbers of the elderly, disabled and mothers with young children either could not or should not work full-time even if they were able to obtain suitable jobs.

A better public welfare program

The Advisory Council on Public Welfare, appointed by the Secretary of HEW under Congressional mandate to review the Nation's public assistance programs, has recommended a new approach, the main features of which are:

(1) A National minimum standard for public assistance payments below which no State may fall.

(2) A nationwide comprehensive program of public assistance based upon a single criterion: Need.

(3) A uniform, simple plan for Federal-State sharing in costs of all public welfare programs which provides for equitable and reasonable fiscal effort among States, and recognizes the relative fiscal capacity of the Federal and State governments.

(4) Comprehensive social services readily accessible, as a right, at all times to all who need them.

(5) All welfare programs receiving Federal funds administered consistent with the principle of public welfare as a right.

These objectives should be reached as soon as possible. In the meantime, the President has recommended a first step, namely, that States be required to raise cash payments to welfare recipients to the level the State itself sets as the minimum for subsistence and to bring these minimum standards up-to-date annually. Since in most States even minimum public assistance payments are well below their own needs standards, acceptance of this proposal would result in a significant though still inadequate improvement in public assistance standards. It must be recognized, however, that since the situation is the worst in the poorest States, additional Federal matching funds must be made available even to meet this limited objective.

In addition, the following measures should be authorized:

1. The program of Aid to Families with Dependent Children—Unemployed Parents, now voluntary with the States, should be made mandatory and the so-called "man in the house rule," where it is in effect should be immediately eliminated. Furthermore, assistance should not be denied to needy mothers of dependent children because of presumed employability. These changes would not only help needy families to try to meet minimum subsistence needs but they would also stem the tide of family disintegration resulting from arbitrary and cruel rules which often govern eligibility for public assistance.

2. Adult recipients of AFDC payments often lose in their welfare payments dollar-for-dollar any money they earn when they are able to obtain jobs. This is a senseless penalty which destroys employment incentives of the employable poor. Earnings should be permitted up to some reasonable amount before welfare payments are reduced.

3. Minimum standards should be required in housing occupied by public welfare recipients, the rents of which are paid from public funds. Public welfare should stop subsidizing slum housing.

4. Aid to the permanently and totally disabled should be improved by including the relatively short-termed disabled, recognizing partial disability which is seriously incapacitating and eliminating the present minimum age 18.

5. Detailed demeaning investigations of public assistance applicants and recipients should be eliminated in favor of less costly and more democratic methods of determining eligibility. These should be consistent with constitu-

tional and statutory rights and should not violate the privacy or dignity of individuals seeking assistance.

6. Child welfare programs should be extended and improved. Better services are needed for care and protection of children including foster care, day care and institutional services.

[Adopted December 1965 by the Sixth Constitutional Convention—AFL-CIO]

OLD-AGE, SURVIVORS AND DISABILITY AND "MEDICARE"

The Social Security Amendments of 1965 marked the most significant advance of social legislation in recent times. The passage of "medicare," old-age, survivors, and disability insurance cash benefit increases, and general improvements in the social security law reflect an increasing awareness on the part of society, not only of a greater obligation to care more adequately for our senior citizens, but also of the importance of our social insurance system as a vital part of a dynamic economy.

Organized labor played a leading role in the passage of this legislation. Now, with this successful achievement, we must turn our attention to those social needs that are still unmet. The conclusion of the "medicare" fight provides an opportunity to step up the fight to complete unfinished work, to make basic improvements in the Social Security Act, and to reevaluate our social insurance system in light of economic and technological change.

Substantial increases in cash benefits and in the contribution and benefit base

Many of our aged are living in poverty. The Social Security Administration estimates that somewhat more than a third of the nation's aged social security beneficiaries have incomes below the poverty line. The aged constitute about one-fifth of all the poor in the nation. The benefit structure of the social security program has not kept pace with the increase in the general standard of living because it has not reflected the increased productivity of the nation. Those who have helped to build our society are particularly entitled to share in the economic gains of that society. Unfortunately, benefit increases have done little more than keep abreast of the cost of living. The 7-percent benefit increase provided for in the 1965 social security amendments, for example, does no more than bring the purchasing power of social security benefits in line with the increases in the cost of living that have taken place since 1958, when the last general benefit increase was enacted.

Since social security benefits are the major, and in a great many cases the sole, reliance of our people for income security in old age, a substantial increase in the general level of social security benefits is needed.

In conjunction with such an increase in benefit levels, a substantial increase in the contribution and benefit base—the maximum amount of annual earnings that is taxed and counted for benefit purposes—is also needed. It is imperative that the base be kept up to date with changes in earnings levels; failure to do so has serious effects on the benefit protection provided under the program because an increasing number of workers have earnings above the base amount and therefore get benefits that are related to a smaller and smaller part of their full earnings. While the increase in the contribution and benefit base to \$6600 provided by the 1965 amendments will make up some of the ground that has been lost by failure to adequately increase the base over the years, a \$6600 base only temporarily restores the situation that would have existed under a \$3600 base in 1950, the year the \$3600 base was enacted. A further substantial increase in the base is needed to restore the situation that would have existed under the original \$3000 base in 1935, the year the program was enacted.

Failure of the contribution and benefit base to keep pace with rising earnings levels also weakens the foundation of the financing of the program—the proportion of the nation's payrolls which is subject to social security contributions.

To provide the aged with the adequate living standard they deserve, social security cash benefits should be increased by at least 50 percent and the contribution and benefit base should be increased to \$15,000. Since these increases are quite substantial they may need to be accomplished in several steps over the next few years.

After the benefit levels have been substantially improved and the contribution and benefit base has been brought back in line with the increase in earnings

levels that has taken place since the program began, Congress should examine the desirability of automatic adjustment of benefits to changes in prices, so that the buying power of the benefits can be maintained, and for automatic adjustment of the base to changes in average earnings levels, so that there will be no future deterioration in the proportion of annual earnings counted toward benefits.

A Government contribution to the financing of the social security system

In order to make the social security program quickly effective in its early years, it was the decision of the Congress to provide for the payment of full-rate benefits to people who were already old at the time their work was first covered under the program, even though only a small percentage of the actual cost of the benefits being paid to these people was met by the contributions they and their employers paid. This has been sound public policy, necessary to help prevent widespread want and destitution and to contribute to the social and economic security of the Nation as a whole. The cost to the program resulting from these payments, though—about one-third of the total cost—should not be charged to future generations of workers and their employers. It is entirely appropriate that the cost of getting into operation a national social security system from which society as a whole benefits, should be borne by the population as a whole.

Retirement age

The social security program should recognize to a greater degree than it does now that the decision to retire varies with physiological, psychological, and occupational characteristics, and also with the state of the labor market. Greater flexibility in the age at which benefits are available to older workers would allow more rational choices based on individual circumstances. To that end the OASDI system should attempt to establish a flexible zone of retirement from age 60 to 65 with an increasing benefit amount for each succeeding year. To the same end many older workers who are unable—because of their age, their impairments and the hiring practices of many employers—to obtain work that is related to their skills cannot get retirement benefits because they have not reached retirement age and cannot get disability benefits because of the requirement of present law that a worker must be unable to engage in any type of substantial gainful activity. The recent amendments provided disability benefits for older workers disabled by blindness if the worker is unable to engage in his usual occupation; all older disabled workers—regardless of the reason for their disability—should be permitted to qualify for disability benefits if their impairments prevent them from engaging in their usual occupation.

Hospital and medical insurance

The basic hospital and medical insurance programs provided for our older citizens must be improved. A first priority, however, should be to extend the provisions of the program to those who receive social security disability insurance benefits. All of the reasons for providing "medicare" for the aged apply equally to the disabled. Like the aged, these beneficiaries are a low-income, high-health-cost group and consequently have considerable difficulty in obtaining adequate private health insurance protection. Since disabled people experience a significant reduction in income and have little prospect of improving their financial position, adequate private health insurance is beyond the means of a great many of them. Also, there is no reason why in time the medicare program should not be extended to cover widows and surviving children receiving social security cash benefits and other social security beneficiaries.

The \$3.00 monthly deduction for the voluntary medical plan and undue limitations on the amount and duration of care should be eliminated and hospitals permitted to include services of certain specialists in the basic insurance plan. Despite shortcomings, the voluntary medical plan represents an excellent "buy", and we urge all those eligible to take advantage of this plan at the earliest opportunity.

Disability insurance

Though the new social security amendments made some improvements in the disability provisions, there remain serious inadequacies in cash benefit protection against earnings lost from disability which should be met through the social security program. Under present law, disability benefits are not payable until after a worker has been totally disabled for at least 7 months and only if the disability is expected to result in death or to last for a continuous period

of not less than 12 calendar months. Many workers who are totally disabled for extended periods of time are therefore not eligible for social security disability benefits. These workers are likely to be without either earnings or benefits at a time when their expenses may be unusually large. The disability provisions should be amended to reduce to 1 month the waiting period for disability benefits and to provide for payment of benefits on the basis of total disability without regard to its expected subsequent duration.

Other changes

There are many additional improvements that should be made in the social security program; one of these should be singled out for mention. Because a greater number of years must be used in determining the average monthly wage for men, the basic benefit amount for men is generally lower than it would be for women if they had the same earnings. The period for computing benefits for men should be based, as is now the case for women, on the period up to age 62, instead of age 65 as under present law. Such a change would increase the monthly benefit amounts that would be paid to men and their dependents.

The AFL-CIO urges prompt action to secure these improvements in the social security system, including applicable provisions of the Railroad Retirement Act. Therefore, be it

Resolved (1) That social security benefits be increased at least 50 percent in order to alleviate poverty among our aged population and to permit older people to participate in the increased standard of living that they have helped to make possible, and that the contribution and benefit base be raised to \$15,000 to restore the situation that existed in the early years of the program with respect to the proportion of covered earnings taxed and counted for benefit purposes. Because of the scope of these increases they should be accomplished in several steps over the next few years.

(2) That the Congress of the United States provide for the payment of contributions to the social security trust funds from general revenues.

(3) That the social security program should provide flexibility by establishing a zone of retirement from age 60 to 65 with an increasing benefit amount for each succeeding year. Benefits should also be made available to older people who are below the normal retirement age and who are not totally disabled but who are no longer able to engage in their usual occupations.

(4) That the "medicare" program be liberalized and broadened to include immediately those receiving social security disability benefits and, in time, all social security beneficiaries.

(5) That the waiting period for disability benefits be reduced to one month and that benefits be payable as long as the total disability lasts beyond one month.

(6) That the period used in determining men's retirement benefits should end at age 62 as it now does for women.

The CHAIRMAN. Mr. Meany, we thank you very much for your statement. We appreciate your coming to the committee.

Mrs. Griffiths.

Mrs. GRIFFITHS. Thank you, Mr. Chairman.

Mr. Meany, at the top of page 2 you point out that social security protects the widows and children of breadwinners who die.

Mr. MEANY. Yes.

Mrs. GRIFFITHS. How many women does the AFL-CIO organize?

Mr. MEANY. How many what?

Mrs. GRIFFITHS. Women does the AFL-CIO organize? How many women in your unions?

Mr. MEANY. We keep no figures on the background of the sex of our membership, or the color of their skin, or their religion or anything like that.

Mrs. GRIFFITHS. You do have women, though?

Mr. MEANY. We do have large numbers of women.

Mrs. GRIFFITHS. Do you have any objection to all workers having the same rights under social security?

Mr. MEANY. None whatsoever.

Mrs. GRIFFITHS. So that you would support an amendment that says that widowers and children of workers who die have the same rights?

Mr. MEANY. I don't get that.

Mrs. GRIFFITHS. Let me give you an example. If a man works under covered employment for 10 years, it is conceivable that 75 years later his widow and children could be drawing on his rights. If a woman worker is in covered employment for 10 years, 11½ years after she has left the work force, her husband and children have no rights at all. Do you support that?

Mr. MEANY. Well, I certainly see there is some inequity there and I certainly would want to take a good look at it.

Mrs. GRIFFITHS. I hope you not only take a good look at it; I hope you support the fact that a woman who has worked under covered employment has exactly the same rights as a man who has worked under covered employment.

Once those rights are established there is no reason for her right to die. I had an example here the other day of a woman who had paid partially for the support of her husband for 30 years in a mental institution. She left the work force at 65. He can't collect one cent on her right, and yet any wife could have collected half the social security of a man worker.

I would like to point out to you that in my judgment the people on whom this tax falls most heavily are working families. For instance, if a man is doing a little moonlighting he can add together the amount of tax he pays in each job and if he is overpaying the base he gets a credit on his income tax, but if a working couple both pay the total base they don't get a credit on their income tax.

They just pay, and yet the wife is getting very little in the way of rights. It seems to me that the AFL-CIO should be first in supporting her rights, that there should be no distinction between workers.

Mr. MEANY. Well, we have taken that position and I certainly think we should take it here, but I am not familiar with the example that you recite. I would like Mr. Seidman to give you his opinion on that.

The CHAIRMAN. Mr. Seidman.

Mr. SEIDMAN. Mrs. Griffiths, we have considered very seriously some of these proposals which you have made and have brought to public attention.

I think a distinction should be made between the two which you suggested. The one, as I understand it, deals with the problem, and it is an unusual problem, but nevertheless does exist, where a husband has been dependent on a wife and where as a widower he is not entitled to the same benefits as the wife would be under similar circumstances.

I think our position would be that this is a situation which appears to require correction and we think that this is the kind of thing which ought to be looked into very seriously.

The second proposal, as I understand it—correct me if I am wrong—involves somehow lumping together the earnings of a husband and wife for social security purposes and, while we haven't

looked into all of the problems involved in this, we understand that it would create a great many technical difficulties and also new types of inequities, even thought it might be correcting some other inequities, and that therefore this is something that we would be lot more reluctant to support just out of hand.

Mrs. GRIFFITHS. If you do not support putting their earnings together for the purpose of drawing benefits, then why do you support permitting both of them to be taxed? Why do you support a husband and wife each paying the total tax? Do you feel that this is simply a tax on employment and that these people, this couple, should pay the tax twice?

Mr. MEANY. Well, the tax is related to the earnings that people have and, as we know, the benefits depend on eligibility. Now, there are some people who because they are in the labor force a short time, or for other reasons, pay taxes and never achieve enough of an earnings record, an employment record, to be eligible for benefits, so that these things are not always directly related, but it seems to me that there would be no way of saying that a wife should not pay the contribution or the tax on her earnings.

This is something which is related to earnings and I don't see how this could be separated.

Mrs. GRIFFITHS. Of course, at the present time that wife who is paying that tax is actually paying for the wife who doesn't work. That is really what it amounts to. She is a person who is maintaining the person who doesn't work, not the man who works. Now I would like to ask you, since you are taking from the young to support the old and from the industrial worker to support the rural worker, why do you support a level of benefits whether you are in the rural area or in the industrial area, that is, a \$1,900 payment into a rural area would be in some instances more than people had ever earned.

They would survive exceedingly well. They may be paying as little as \$12 or \$15 in taxes on their property, whereas with \$1,900 in an industrial area they would barely be able to live on it.

Why don't you make it on the basis of not just the poverty level throughout the country, but what it would be in the area in which you live?

Mr. MEANY. In the first place, we are using the poverty figures to show the inadequacy of social security benefits. We are not saying that the social security benefits should be at the poverty level.

But, in addition to that, it seems to me that we never had any kind of social insurance in this country or anything similar to it where we have differentiated between people who are living in rural areas and people who are living in urban areas.

The fact that people in rural areas have earned lower incomes has simply meant that there has been more poverty in rural areas, and I don't see why we should at this point begin to have this kind of discrimination introduced in the social security law.

Mrs. GRIFFITHS. But you are actually discriminating against the urban worker. A definite level of payment throughout the United States discriminates in reality against the urban worker. It is not dollars that counts. It is what you can buy with them. And in an

urban area just property tax or rent would be heavier than it is in rural areas.

The property tax or the rent of the urban beneficiary would be so much higher than it is in a rural area that you have in fact discriminated against the urban workers, and yet it has been the urban workers that have made possible the payment to everybody.

Mr. MEANY. Our observation has been, Mrs. Griffiths, that the living costs throughout the United States, not just as between rural and urban, have been coming closer together and we think that the benefits should be set at a level of adequacy which would be adequate for urban workers and we don't think that this would give a windfall to the rural workers.

Mrs. GRIFFITHS. Thank you very much.

The CHAIRMAN. Mr. Curtis.

Mr. CURTIS. Mr. Meany, in your presentation you simply relate to what is being done in the governmental area as far as retirement of our people is concerned, but, as I have understood it, social security has always been presented as a base upon which other programs will be built. Is that your understanding, too?

Mr. MEANY. Well, we, of course, in our collective bargaining agreements relate our pension benefits in some cases to social security, but I don't see what that has to do with raising the social security benefits.

Mr. CURTIS. Well, I am very disturbed if you don't see what it has to do with it because I think one of the key problems that has faced this committee in the past in dealing with social security, and presently faces us, is how do we coordinate what is being done in the private sector with what is being done or might be done in the governmental sector.

We are all interested in attaining the very fine ideals that you set forth in your paper. The argument, though, is over how do we best do it, what is the method.

Mr. MEANY. How could you base the Government payment on what people get privately?

Mr. CURTIS. I am not arguing that, Mr. Meany.

Mr. MEANY. There are all different sorts of plans.

Mr. CURTIS. What I am saying is one of our concerns is how do we relate the two to each other. Let me illustrate by being specific. When you move a base up to \$10,800 you are moving quite heavily into an area where a great deal of the private retirement plans are financed.

Now, maybe we still want to do it, but in order to understand it I think we must relate our discussion to some degree with what is going on in the private sector. However, your paper has no recognition that anything is going on in the private sector. It is almost presented as if the only thing that our people have that will take care of their retirement and their other problems is their governmental program.

You see what I am trying to bring out?

Mr. MEANY. We have certainly got to base it on the assumption that there are people that only have this, that it is the only thing they do have.

Mr. CURTIS. Yes, then let's relate it to this—this is not a program, Mr. Meany, that just relates to that group of people. This covers people that are perfectly able to take care of themselves. I would

argue that well over 80 percent of our people don't need anything like this at all.

Mr. MEANY. The figure, Mr. Curtis, is just the opposite; just the reverse. Eighty-five percent of the elderly are not covered under private retirement systems, so you are worrying about the 15 percent getting a little too much?

Mr. CURTIS. No. I think you are missing what I am trying to get across. I am not trying to argue with you at this point. I am merely trying to get a base where we can have an argument, and one of the arguments would be what is the balance between those who can provide for themselves and those who can't. You say that you think my figure of 80 percent is the reverse. This begins to get things out in the open where we can have a fruitful discussion, but your paper makes no reference at all to what goes on in the private sector. So that this committee can't consider whether to move to improve our retirement programs for our people through, for example, the social security program, or should we do this through our private pension programs, which to one extent is affected by Government inasmuch as we do give tax deductions for pension plans that meet certain qualifications. So we are in that business, too.

This criticism, and it is criticism, that I direct against your paper is the same criticism I directed against the paper presented by the Secretary of HEW.

All the discussion in these papers is around the Government program without any attempt to relate it to what goes on in the private sector to see what happens, if we were to move the Government program as you recommend here, what impact does that have on the pension programs and other retirement programs that also exist. Is this a better way of improving the retirement for our people or is a better way to encourage it to remove inhibitions from developing the private programs, including the pension program that your unions get into their union-management contracts.

That is what I am trying to direct your attention to.

Mr. MEANY. Well, I just don't agree with you. I think that we are concerned with a system which was established some years ago. It is a governmental system. Now, in the meantime if some people have been able to help themselves through a negotiated pension plan, and that is only a small percentage, I don't see why we should relate it. What do you mean by relating this? How could you relate this, Mr. Curtis?

Mr. CURTIS. Let me say that your union people have as a base, social security. Then they go in and argue with management that "we want this kind of pension plan on top of it." In your negotiations, the two systems are interratered so that you end up with a comprehensive program.

Mr. MEANY. They don't go to management and say they want that. They say "we want more money and we want it in the pension plan." In other words, what they get out of management they earn. That is part of the wages.

Mr. CURTIS. I am not arguing that it isn't. In fact, I am all in favor of it, Mr. Meany. I am simply saying that that is what I am talking about, how do you in your specific labor-management con-

tracts relate the social security that your people are getting to what they are going to get through the pension plans. If you move more heavily into social security what impact does that have on building up your pension plans that are——

Mr. MEANY. That would have a different impact at every bargaining table.

Mr. CURTIS. Exactly.

Mr. MEANY. You don't think the employer would buy a set of figures from a negotiator for the union that gave a false picture of what social security would do or wouldn't do?

Mr. CURTIS. Well, I hope not, but I would think that with the wealth of information the AFL-CIO has you could have given us some data as to what is happening in the private area. What have you people been able to do with your pension programs? What is the potential for further developing the pension program? What happens to that potential if you move forward in this area using the payroll tax to this extent and applying it to a base of \$10,800 of wages?

Now, I think you answered my question. You just haven't thought about it, and I am sorry because I think that thereby your paper doesn't provide as much real information as we wish.

Mr. MEANY. I am sorry that you are sorry, but I just don't see the relation that you put between the two. One is collective bargaining with an employer for services to be rendered and the other is a Federal social security system.

Mr. CURTIS. Oh, I know you don't understand my point and maybe I am just not very clear in getting it across, so I guess we can't pursue this any further.

Let me say one specific thing in reference to your paper, on page 10, I believe it is, you refer to early retirement, and I think this is a very important point and a point that I sought to make, Mr. Meany, in minority views that I wrote to accompany H.R. 8282 in the last Congress on unemployment insurance. I said I thought that the biggest problem that was facing us in the field of unemployment was in the area of getting our retirement systems set up so there can be early retirement for the very reasons you list here, automation and ill health.

But this also bears on the basic point I was asking you because it isn't just early retirement for social security programs. It is also early retirement in the pension programs, and the other private retirement systems that exist in our society.

However, as I say, you have responded to my questions and it is just a regret to me that neither the Government through the Secretary of HEW nor the great AFL-CIO seem to understand that we are talking about an entire social system of which Government's part is one thing, but another big part is the private programs. It becomes of great concern how you relate the two.

Mr. MEANY. Let's understand one another. My position is we should not try to relate the two. Let's put it that way.

Mr. CURTIS. That is even worse.

Mr. MEANY. Oh, no, it is not even worse, because one is private and the other is Government.

Mr. CURTIS. Let me pursue it just a little further. We have a problem in this committee of trying to relate social security with the rail-

road retirement system to dovetail them to be sure that they work together. We have the same problem of trying to corrolate the program with veteran's pensions, so when you say that you don't even want to try to relate them——

Mr. MEANY. You are talking about railroad retirement. That is under Government supervision.

Mr. CURTIS. The test in your mind then is simply if it is Government, but how about veteran's pensions? How about civil service retirement? We try to relate that, too, to social security. We try to relate the State and local governmental employee retirement systems, too.

Mr. MEANY. I am not quarreling with that at all.

Mr. CURTIS. Then why do you object to our trying to relate it to the great pension plans which to some degree are Government, to the extent, at any rate, that there is a tax deduction for them and we do set up certain standards by law which these pension plans must meet if they are to qualify.

This committee just recently, the Congress, passed out a further development of the retirement programs for the self-employment, professional people, the Keogh bills which again require, I would argue, relating those programs to the basic social security program.

But you don't want us to attempt to relate them, as I understand it.

Mr. MEANY. Not those that are strictly in the private sector.

Mr. CURTIS. Thank you.

The CHAIRMAN. Any further questions?

Mr. Meany, we thank you again for coming to the committee and discussing this matter with us. We appreciate your doing so.

Mr. MEANY. Thank you.

(The following letters were received by the committee:)

AMALGAMATED MEAT CUTTERS &
BUTCHER WORKMEN OF NORTH AMERICA,
Chicago, Ill., April 5, 1967.

HON. WILBUR D. MILLS,
Chairman, Committee on Ways and Means, House of Representatives,
Washington, D.C.

DEAR MR. CHAIRMAN: In the view of our Union, the social security bill which your Committee is currently considering is one of the most important pieces of legislation to come before the 90th Congress. It is basic to the welfare of the young and old of our nation alike.

The bill proposed by the Johnson Administration would increase the benefits to retired people, to widows and survivors, to the disabled, to the sick and to the needy. It would bring benefits closer in line with the current needs of Americans.

Our Union believes that such increases are extremely necessary since benefits provided under current law are shockingly low. Current law simply makes social security beneficiaries another part of the poverty group in American society.

We do not think that the Administration proposal is a panacea. In fact, we would have welcomed a bill that would have provided more and higher benefits. However, we believe it is the first step toward making the social security a realistic basis for meeting the needs of the program's various beneficiaries.

We strongly endorse the testimony delivered before your Committee by President George Meany of the AFL-CIO. We urge the Committee will take the actions which he has recommended.

Sincerely yours,

THOMAS J. LLOYD,
International President,
PATRICK E. GORMAN,
Secretary-Treasurer.

RAILWAY LABOR EXECUTIVES' ASSOCIATION,
Washington, D.C., April 7, 1967.

HONORABLE WILBUR MILLS,
Chairman, Committee on Ways and Means, House of Representatives,
Washington, D.C.

DEAR MR. CHAIRMAN: In testifying before your Committee on the pending social security measures recommended by the Administration, President George Meany of the AFL-CIO expressed our position with respect to the proposed taxation of railroad retirement benefits.

To insure against any misunderstanding with respect to the position of the standard railway labor organizations represented by our Association, I wish to advise that the Railway Labor Executives' Association cannot support any measure which will provide for the taxation of railroad retirement benefits. We find no justification at this time for a departure from the long-established principle that such benefits shall be tax exempt.

Sincerely yours,

DONALD S. BEATTIE,
Executive Secretary.

The CHAIRMAN. Mr. Robinson, Mr. Cohen, and Mr. Newton, Mr. Robinson, will you deliver the statement?

STATEMENT OF JOHN ROBINSON, CHAIRMAN, CITIZENS COMMITTEE FOR RESPONSIBLE GOVERNMENT; ACCOMPANIED BY LESLIE H. COHEN, LEGAL COUNSEL; DONALD C. NEWTON, INSURANCE ACTUARY; DR. THOMAS H. SULLIVAN, MEMBER, BOARD OF DIRECTORS

MR. ROBINSON. Yes, sir. I will deliver the main statement, but I have asked these three gentlemen to add remarks.

The CHAIRMAN. All right. If you will introduce yourself for the record and the gentlemen with you we will be glad to recognize you.

MR. ROBINSON. Yes, sir. Mr. Chairman, I am John Robinson of Syracuse, N.Y. I am chairman of the Citizens Committee for Responsible Government.

On my immediate right is Mr. Donald Newton, a member of our board of directors, on my immediate left Mr. Leslie Cohen, our counsel, and to his left Dr. Thomas Sullivan, one of the members of our committee, and we deeply appreciate the opportunity to appear before this body today.

TOPICAL OUTLINE

The entire concept of medical assistance for needy people could be rejected by the citizens due to an increasingly heavy administrative and financial burden.

Examples of problems and costs being experienced in New York State—problems confronting us due to legislatures handing over broad powers to administrative agencies:

New York State medicaid program not medical assistance for needy people but, is a supplemental income plan.

Objection to proposed formula of Federal participation in MA—medical assistance—for families whose earnings are no more than 1½ times the maximum income standards for cash welfare payments.

A complete redefinition of the word “needy” must be made.

Amending philosophy—limit Federal participation in full payment of medical bills to those totally dependent upon the State

for their everyday subsistence. Provide assistance, complete with deductible and coinsurance provisions, for the rest of the population in cases of catastrophic cost.

Compulsory health insurance not needed if present plans are redrawn and brought together. Compulsory health insurance now, with existing plans unchanged, would actually be a national health service.

The effects of such a program upon the critical aspect of the doctor-patient relationship.

We are speaking for and truly represent hundreds of thousands of people in New York State who are totally dissatisfied with New York's implementation of title 19 of the Social Security Act of 1965.

The purpose of this title is medical assistance for needy people. It has been given the nickname of "medicaid" in New York State to differentiate from title 18 known as medicare.

We commend the basic concepts of title 19 but we deplore the results that we have experienced in New York State thus far. In front of you is a packet of reference material. Don't be scared, gentlemen. We are not going to go over all of it, but we do consider it germane to today's discussion and it also includes our credentials. We will limit our vocal remarks to the more pertinent points in due consideration of your time.

Exhibit I is a dissertation—I think we will call it that—on the horrible mess New York State has made of your plan of medical assistance for needy people.

There are also some other reference points we make. It is apparent to us that both Congress and we in the Empire State have problems very similar in nature, albeit yours are magnified by about 50 times.

We both have administrative agencies which have been given a blank check that has been coupled with broad powers of interpretation, and with these have distorted the noble concept of medical assistance for needy people.

In New York, medicaid is in reality a supplemental income plan of an indeterminate and unlimited amount. Because of such distortions our committee is greatly concerned that the entire concept of medical assistance will be rejected by an irate citizenry due to an increasingly heavy administrative and financial burden.

Gentlemen, the cost of the New York program is rapidly rising to the levels predicted last summer, both by us and you people. We are afraid the total costs will be so high that they will destroy our ability to assist the indigent.

Please bear in mind that as those people who can well afford the majority of their medical bills come to the public trough for payment, they quickly use up the available moneys and place a tremendous burden on the administrative facilities.

Thus, persons truly in need of public assistance experience difficulty in obtaining authorization for these expenditures due to a lack of funds and overburdened staff. We have already experienced this in New York State ever since the implementation began back on the first of May.

Welfare expenditures have risen dramatically during this most prosperous era in your country's history, and yet the average citizen is demanding that the local administrators expend every effort to keep

these costs to a minimum, while at the same time pressure is exerted at State and Federal levels to expand these programs.

The local area is required to share in the costs of these programs which they may not want, have no voice in, and, as in New York's medicaid, absolutely cannot afford.

We have counties in our State where 70 percent of the population is eligible for medicaid due to our high levels.

To digress for a moment, in New York State the title 19 program, medicaid, covers every conceivable item of medical expense, including transportation to and from the physician's office, dental care, glasses, prescriptions, trips out of State if required.

Now, with over 70 percent of the county's population eligible and that county being required to furnish somewhere around one-third of the total cost, you can imagine what this does to taxes, so you now have these two divergent forces meeting head on, governmental pressure to expand, local pressure to conserve.

Gentlemen, you cannot legislate an individual's feelings, nor can you continue to broaden the indigent programs without experiencing a broadening rebuttal from the other segment of the population.

The increase in users, that is, medicaid cardholders, resulting from New York's program, has posed problems beyond just those of funds and staff.

Other health programs in our State have been neglected due to the overburdened medicaid. It has become a major task to find medical facilities for those who in the past relied on clinics for much of their medical treatment.

These problems are magnifying every day. If you will recall, back when this program was first put in Governor Rockefeller and the department of welfare stated that only 2 million people would use this program in New York State.

That was an increase of one-third. He has been proved wrong. We now have at least a 100-percent increase in our use and the rate of application for the medicaid card has risen dramatically since January 1 when we compiled some of the information in our exhibit.

The rate is now twice that rate given in our exhibit. Approximately, in the implementing counties, one-half of 1 percent of the counties population each week is now applying for the medicaid card.

There will be no end to this run on the public bank until the basic philosophy surrounding these programs is changed. Please don't let our State officials or any other agency seduce you with low-cost and user estimates.

We ask that you not only review the various cost and budget charts included in exhibit IV, but insist on a true audit of the State program.

Right now we are being told by the State that in 1966 we have taken care of more people and the overall cost was \$100 million less than in 1965.

This is somewhat incredulous, but the intent of this dance may be very obvious. We are getting a low figure for State consumption. Possibly a high figure will come down here to you.

As a matter of fact, this year our welfare commissioner and our Governor cannot agree on what medicaid will cost this year. They are about \$80 million apart. But through other machinations it is quite obvious that our State government is greatly alarmed over these costs.

County budgets which we have been given reflect a 76-percent increase, 1967 over 1966, for medical assistance programs.

So it is no wonder that our Government continues to call for full Federal support of the medicaid. Since he considers half of our population needy, and I believe this is a higher percentage than the Appalachian region, we have suggested quite often that the Governor apply for disaster relief in lieu of medicaid reimbursement.

Last week while we were preparing for this appearance one of our board members asked if this trip would be worth the effort and expense. He was referring to articles appearing in the various newspapers wherein State welfare commissioner, George Wyman flatly predicted the New York medicaid program would survive these hearings on social security changes.

The headline actually read, "Congress Is Seen Sparing Medicaid." That was in the New York Times on March 1.

Commissioner Wyman was referring to I believe an administrative amendment in H.R. 5710—we have not been able to get a copy of that bill yet, by the way—which is currently before the Congress.

This promotes a formula limiting Federal reimbursement to families earning no more than $1\frac{1}{2}$ times the State's maximum income standards for cash welfare payments.

He predicted that this administrative amendment would be passed as if he had an inside pipeline to the workings of your committee and such a formula would then justify New York's eligibility levels.

According to Mr. Wyman, our income standard right now is \$3,931 for a family of four, plus payments for special needy items such as furniture, appliances, extra clothing, and what have you.

He stated that this figure will be raised in May due to the cost of living adjustments—ergo continuance of the current New York levels of eligibility.

One and one-half times the amount he is referring to is our \$6,000 figure for a family of four. Just last May Commissioner Wyman stated that these eligibility levels were none of the Federal Government's business, so, our board member wondered just who is establishing the policies of title 19, Mr. Wyman or the Congress, and thus whether our appearance here today was worthwhile.

We feel that it is worthwhile. It should be noted at this point that Commissioners Wyman and Ingraham have unlimited and dictatorial control of all aspects of this program in our State.

Commissioner Wyman has already stated that he will ask for higher eligibility levels when he deems it necessary, and he does not need legislative approval to change these levels.

Another aspect of the program that concerns us is that handing over of broad powers to the administrative bodies, and I will ask our counsel, Mr. Cohen, if he will speak briefly on the problems confronting us to date due to this legislative relinquishment.

The CHAIRMAN. Mr. Cohen.

STATEMENT OF LESLIE H. COHEN, LEGAL COUNSEL, CITIZENS COMMITTEE FOR RESPONSIBLE GOVERNMENT

Mr. COHEN. Mr. Chairman, members of the committee, first of all, I think the best way—it may seem inconsistent to you—to describe the manner in which New York State implemented title 19 to state

without any hesitancy that there is no, there is no, medical assistance law in the State of New York.

This statement may seem inconsistent to you with the fact that we are here today to discuss the manner in which New York implemented title 19, but the facts I will set forth will show that there is nothing whatsoever inconsistent about this position.

In the spring of 1966, the New York State Legislature adopted chapter 256, title 11, as an amendment to the social security welfare law of the State of New York. This legislation was enacted for the express purpose, as stated therein under section 363(a) of implementing title 19 of the Federal social security law.

The legislation begins with, under section 363, a "Declaration of Objects" wherein it is stated that medical assistance for needy persons is declared a matter of public concern in the State of New York, and in furtherance thereof a program is to be established.

This statute does then continue under section 363(a) and 364 to delegate to the board of social welfare and the department of social welfare the following:

(a) The board shall make such rules and the department shall make such regulations, not inconsistent with law as may be necessary to implement this title.

(b) The board shall establish by regulation reasonable standards which shall be comparable for all groups for determining eligibility consistent with the provision of the title and rules of the board.

(c) It shall promulgate the qualification required of physicians and dentists, et cetera, employed by the welfare districts.

The statute contains no provisions as to who shall be eligible and the manner of actual operation of such program, but bests total authority in this regard in the board of social welfare, department of social welfare and in some instances with the aid of the department of health.

There is no requirement that any plan or program be approved by legislative action or be required to be reported and reviewed by legislative act prior to its becoming effective.

You have heard much—you heard Mr. Meany talk, you have heard many others talk before us, and you will hear much talk after us—concerning costs, cost analysis, and there are many inconsistent opinions specifically in this regard about the New York plan.

But the most important and most salient aspect of this situation in my opinion is that the entire health of a State, and not a small State, a State of 18 million people, and a considerable potential financial burden, not only to New Yorkers, but to the Federal Government, and remember that all of us are here today not as New Yorkers—we are also citizens of the United States—rests solely in the hands of a 14-member board appointed by the Governors of the States, and not bound to legislative review.

It is in truth a complete divesting of responsibility by our legislature and the placing of this most serious situation under total and unquestioned control of State administrative agencies.

The people of New York were never given the opportunity to have their views put forth by their elected legislators. They have no means of control whatsoever at this stage over the future of this program. There is therefore a definite turning away from the democratic process in a matter of vital concern.

Let me digress for just 1 second to say to you that these comments are not in any way a matter of political or social philosophy. They have nothing to do with it.

Many times it has even been marked to me how can a Democrat like me be speaking this way. Well, it is no shame on my part whatsoever because I don't think that it is true of Democrats that they don't care about the system of government.

All the people in this Nation need the machinery of government and we can't disregard it. We can't disregard it in the field of health or in any other field. The people had a right to have their legislators ear in this.

We as a Committee for Responsible Government would respectfully urge upon you the following things in your deliberations on this matter:

(a) That no State plan implementing title XIX be allowed unless it has received full legislation action spelling out by definite guidelines, who shall be covered and extent of coverage.

(b) That any plan which is the sole byproduct of an administrative agency of any State, wherein said agency has been given unlimited authorities, for creation of such plan and operation of same, be prohibited approval by the Federal Government.

We urge these things to prevent our Federal Government from being raided at the whim of some State administrator, who by his State law has been given unlimited authority to act in this field, and also to prevent our Federal Government from extending further the concept of delegation of power.

We also say to you that our Governor, the Honorable Nelson A. Rockefeller, cannot be heard to complain of discrimination against New York by any action you may take on New York's situation, for he has not yet allowed the matter of public health to be representatively considered by the citizens of this State, and in any democracy such consideration must be a condition which can never be waived by either the executive or legislative branch of Government.

I thank you for your consideration of my comments and I hope they will be an aid to you.

The CHAIRMAN. Thank you, Mr. Cohen.

Mr. ROBINSON. Mr. Chairman, I might add this at this point: That in testimony taken last May at the Joint Legislative Committee hearings, the legislators stated definitely that they could not see New York's medicaid plan, that is, the administrative plan, barring passage of the bill, and none of us is really objecting about the provisions shown in the bill.

The bill itself, which I am sure you gentlemen have gone over, is rather innocuous in its nature. Please keep in mind also that under present law Commissioner Wyman need only stick out his hand and the Federal and State Governments are obligated to fill it.

You can readily see where this incorrectly gives an administrator power of taxation. We do not consider this consistent with our democratic principles.

The current medicaid program in New York State, as we have said quite often, is not medical assistance for needy people. This is a supplemental income plan of an undeterminate and unlimited amount for

that half of our population who have been relieved of any responsibility whatsoever of providing for their medical care.

In exhibit I, there is a table, a budget which was given by Mr. Hugh Jones at these same May hearings last year. You will see where his budget allows this family of four \$200 per month to spend as they please.

He alluded to this surplus when he stated we must then realize that the nagging expenditures caught up with these families, such as installment payments and things of that sort.

We do not feel that title XIX or the intent of title XIX was a supplemental budget. We are in favor and do support quality, State paid, medical care for those totally subsistent upon public funds for their everyday needs, but does this concept of medical indigency which New York State has passed mean that I with a wife, four children and a net income of \$7,700 per year—that is after taxes—cannot afford to treat my family's colds, have their teeth filled, or buy eyeglasses?

We have a judge in our city of Syracuse who is eligible. Yet this one and a half times maximum income formula which you are considering and approved by Commissioner Wyman says that I am incapable of meeting even these simple costs.

Please bear in mind also that the basis of this formula can be adjusted at will, and because the concept of formulas has worked in the past, this is no guarantee that it will work in the future.

I believe New York's present problem is a classic disruption of the formula concept.

I cannot think of a better time or place to voice an objection to this proposed Federal amendment calling for your participation in this program of medical assistance for all of those earning no more than one and one half times a State's maximum income standards for cash welfare payments.

Right from the start there is an automatic escalation factor built into such a plan. A formula of that nature would have been another Pandora's box regarding who is and who is not eligible at any given time, since the levels will change each year.

If I were a Congressman, concerned with the costs of Government, I would look at this formula as an open invitation to other States to raise their levels in keeping with New York.

And certainly great pressure would be exerted in this direction by various groups throughout the Nation as it is now being exerted in New York State. We do not feel a formula concept should be applied to a program of this nature.

Albeit critics have argued that there must be a set eligibility level to somewhat limit the cost of medicaid, we do not feel this criticism is valid, and furthermore, just what is a proper income level at which to determine medical indigency.

The answer, gentlemen, is that there is no such level. Yes, we want Federal and State limitations on this program, but not via a formula method whereby you decide a given dollar amount is the dividing line.

Once the entire concept of medical assistance for needy people is revised, your limitations will automatically appear. The word "needy" must be completely redefined and applied against the full spectrum of our population.

There isn't a one of us sitting here today that could not become medically needy at any time. We are not advocating a national health service akin to England; far from it.

But there must be a limit to the scope of the free ride. There must be a limit placed upon the reliance of the individual upon governmental assistance.

And here is the nub of this very real problem: How to recognize and allow for the medical needs of a family; then how to relieve their anxiety over the cost of these needs, but not their responsibility.

Our answer is this: Limit Federal participation in any plan of full medical assistance only to those persons totally dependent upon the State for their everyday subsistence.

We agree with the view expressed by the Honorable Thomas Curtis in House Report 2224 and urge that above the level of those on public assistance rolls for everyday needs, provision be made to assist families with their overburden, or catastrophic costs, if you will.

Such assistance must be coupled with full measures of deductibles and coinsurance in all areas of Federal participation, and this could be applied to title XVIII as well as title XIX.

We have been very fortunate in having people put some blood, sweat, and tears into our amending plan as is described in our exhibit 3. I would like Mr. Donald Newton to present it.

We feel it is a philosophy applicable to both the State and the Federal Government. Mr. Newton.

The CHAIRMAN. Mr. Newton.

STATEMENT OF DONALD C. NEWTON, INSURANCE ACTUARY, CITIZENS COMMITTEE FOR RESPONSIBLE GOVERNMENT

Mr. NEWTON. Thank you, gentlemen, for the privilege of submitting this testimony.

Medical science is progressing so fast in the discovery and development of techniques and medicines that people have promise of recovery from injury, disease, and chronic impairments where earlier there would have been no hope of recovery or even of survival.

Social concern mandates that these new achievements and resources be available to everyone. But there is one great barrier—the cost is frequently astronomical when measured by earlier experience.

These facts give rise to a new problem—that otherwise independent people suddenly and unpredictably find themselves overwhelmed with medical costs. These are not welfare clients in any normal or conventional usage of the word.

They are in trouble for one reason only—overwhelming, economically devastating medical expense. Before meeting this burden they were economically independent. After recovery from it they should again be economically independent.

Title XIX, as we understand it, was to help such people meet their temporary problems, without making them lifelong dependents. But it has been interpreted in New York State in a very different way. New York has implemented title XIX with legislation which will drain off hundreds of millions of dollars to pay routine day-by-day costs of people able to pay as they have in the past, and induces them to be

permanently dependent on welfare for this segment of their family economy.

It is, we believe, your deep concern that Federal funds are proportionately committed to this unwise and unneeded expenditures.

We have thought through on and constructed a set of amendments which, taken together, would bring this New York plan into conformance with the intent of title XIX. The conceptual basis of these changes and the amendments themselves are, we believe, also your concern, because in our judgment, amendments of title XIX itself must be such as to control the implementing legislation by the States to keep them within these concepts.

PHILOSOPHICAL AND PRACTICAL BACKGROUND OF PROPOSED AMENDMENTS

We recognize that people on welfare have all their medical bills paid for them in full as a part of welfare support. This full payment is necessary for people who are dependent on the State for their living expenses.

We do not oppose this. In fact, we believe medical care for these people should be made far more adequate.

But, we firmly oppose payment from public funds of the entire medical costs of anyone not on welfare. Medicaid now does just this. It pays the routine and incidental expenses of people perfectly able to pay for themselves.

For any person who is not on welfare we urge that the use of public money be limited to those medical expenses which lie beyond his reasonable ability to pay for himself from income, personal resources, and insurance.

The result of this limitation will be to stop the great waste of public funds in paying routine costs and eliminate also the extraordinary administrative expenses made necessary by the multitude of small payments.

Public money can then be concentrated and focused on the critical purpose of helping all citizens who are faced with sudden catastrophic expenses or heavy and long continuing costs of chronic illness.

This is our central concept—that as surely as social conscience demands that the true overburden of medical costs be paid by public funds, public funds must be strictly confined to that overburden or there simply will not be enough money available for this purpose. And we will have failed to adequately help those who need it most.

It is of transcendent importance to have adequate cost controls in this unique area of expense. Adequate medical care is the real objective—perfect medical care is not possible, or yet even definable.

Overuse by reasonable objective standards may take place without the user being aware of it—he is not objective. Abuse can be so subtle that much of it is impossible to root out. The cost of both is heavy and denies both money and facilities to meet pressing needs.

A person cannot be expected to refuse help which comes free when one crosses an eligibility line. In fact there is overwhelming evidence that what is free is overused.

There is only one way in which costs can be controlled and that is through the self-interest of the user expressed in terms of economic

motivation. Insurance companies have long since found this out and developed two types of control which have equal applicability for use by the State. There are no others available, except compulsion imposed on both the individual user and the personnel and facilities he uses.

This we reject on deep philosophical grounds. Without the use of these proven controls the cost of medical assistance will rise steeply and uncontrollably. The State plan can no more avoid ultimate bankruptcy through the lack of them than can an insurance company.

These controls are of two sorts. One is known as a "deductible," the purpose of which is to avoid payment of whatever amount, for a given family, at a given income, may fairly be considered tolerable expenditure in any year's budget.

As to the lower portions of this amount, medical expenses are as normal a demand on income as is food and clothing. The upper portion can be met by reasonable sacrifice and lessening of expenditures for commodities and pleasures which are flexibly included in any budget. This deduction should be neither "insurable" nor "recoverable" from any public source.

When medical expenses rise above such an amount a family begins to be overburdened and will need help in paying them, by resources in this order: First by self-help in further adjusting of its budget—putting these expenses ahead of some desirable but deferrable expense.

Second, by buying insurance to protect themselves and finally, when the first resource would become overtaxed and the second has run out, by public aid.

Throughout this range of expense the family should be adequately assisted but not carried free.

In order that public funds be not involved except where private resources have been first used, there must be a strong stimulus toward making these private sources as adequate as possible. Income at a given moment is fixed, but the other resource, insurance, can be used to multiply many times over a family's ability to be self-sufficient. This translates into the necessity of making it economically worthwhile for a family to purchase as adequate person health protection as possible.

And it means that, although public help must be had before real distress is present, it must be postponed to the outer limit of tolerance rather than coming in early enough to erode the incentive to use private insurance as far as may be. We repeat our conviction that unless the involvement of public funds is thus limited, there will not be enough to provide adequate help for those whose need is truly beyond their capacity to meet.

THE PROPOSED AMENDMENTS DEDUCTIBLE

Of these proposed two amendments the first is the deductible. This is in two parts; both of them are applied annually—on calendar-year basis—to medical expenses of entire family. It is encountered after private plan benefits run out. That is, private plan benefits cannot offset it, but, in proportion to their amplitude, postpone it.

First there is an amount related to income which should be based on the entire income received within the family. This is the true income resource.

We define it as it is found on line 9 of form 1040. The amount of deductible should increase in proportion to income but, at any given income level, it should be less in relation to a larger family than to a smaller one.

The amount of deductible should be sufficient to strongly influence the family to avoid or delay its impact through the purchase of private insurance.

To meet these specifications we suggest that the amount of deductible be equal to the Federal income tax for the family's specific income, computed on the assumptions of joint return and standard 10-percent deductions.

This is within the limits of tolerance and provides a real incentive to recover the lower range of expenses through insurance. A person is motivated toward an adequate private plan because (a) he will want to postpone the impact of the deductible as far into the future as possible with the hope of avoiding it entirely, and (b) if and when he does encounter it, it will be reduced by whatever amount he himself pays in health insurance premiums.

The second part of the deductible concept is related to net worth.

The second component of the deductible is based simply on the equitable fact that a person should involve his assets to a marked extent before looking to public funds. But he should not be forced to pauperize himself, or other vital social objectives are lost. Though a nominal amount of assets should be exempted from involvement, the provident person should not be forced to spend all that he has saved above the nominal amount in order to be equated with the improvident.

Furthermore, there is no equitability in forcing families with certain types of assets to spend them while others possessed of equal quantities of different assets are protected from consuming them.

Thus, we define net worth in very much the same way as it would be defined for purposes of securing a bank loan. Some amount of this net worth is protected from involvement. An amount equal to 20 percent of assets above the exclusion constitutes a net worth deductible which is to be added to the income deductible.

We emphasize that we are not dictating in this concept—as medic-aid presently does—that any particular asset be actually spent. The manner in which a family meets this deductible is solely its concern.

For example, a real estate mortgage may be increased in lieu of selling investments or eroding a bank account designed for education. No doubt this net worth deductible does to some extent penalize thrift but it does not entirely destroy the incentive to save as present medic-aid well may in many instances.

EXPLANATION OF CO-INSURANCE

It is the vital function of co-insurance to keep the user constantly interested in holding down costs. To maintain this influence at higher income levels it is necessary that the higher the income the great must be the portion of expense borne by the user.

In this case there are two additional concerns, essential where public funds are involved.

(a) As expenses mount the portion of them paid by the individual should decline.

So we break down the total amount of expense—after the deductible is met—into “units of expense.”

A “unit of expense” at any income level is equal to one-fifth of that income. Each successive unit of expense incurred by the family is reimbursed to a greater degree than the preceding unit. Thus, the heavier one’s load, the less is the part of it he bears.

I see no way to escape giving you an example. A family with an income of \$10,000 will be reimbursed 70 percent—\$1,400—and itself pay 30 percent—\$600 of its first \$2,000 unit of expense. If expenses continue through an additional \$2,000, it will be reimbursed 80 percent—\$1,600—and itself pay 20 percent—\$400. The next unit is reimbursed at 90 percent—\$1,800—and the family pays 10 percent—\$200. Thereafter reimbursement is 100 percent.

(b) There must be an economic incentive of real substance to motivate the user to first employ private insurance as far as it will go.

Integrated with the concept in (a) on the preceding page, is a compelling incentive for a family to protect itself as far as possible with private insurance. Amounts recovered from private insurance are used in full as offsets for both the individual’s and the State’s share of cost in relation to his first unit of expense, then his second unit of expense, et cetera.

For example, a family illustrated in (a) with \$10,000 income encounters co-insured expenses. But this family has private insurance from which it recovered \$5,000; \$2,000 of such recovery would entirely offset the State’s \$1,400 and his \$600 cost in his first unit of coinsured expenses.

The second \$2,000 of his private plan recovery would entirely offset the State’s \$1,600 and his \$400 cost in his second unit of expense. The remaining \$1,000 of private plan recovery would offset half the cost in his third unit of expense—the State’s \$900 and his \$100.

Thus, he has benefited to the extent of \$1,100 by having a private plan that paid him \$5,000. But, also because he had the private plan the State is relieved of \$3,900 of cost.

This method of providing incentive to own adequate private insurance has a very important additional purpose. No insurer can devise a plan which will destroy the effectiveness of the deductible and coinsurance.

This destruction has been accomplished in relation to medicare benefits. Both Blue Cross and insurers have devised plans which precisely offset both the deductible and coinsurance provisions so widely legislated by the Congress upon your recommendations. This nullifies your purpose.

Our recommended deductible is a corridor which by its nature cannot be offset. Our recommended credit for private plan benefits toward the coinsured units of expense cannot be measured in advance and so cannot be offset.

For such amendments to be fully effective, title 19 must allow both deductible and coinsurance where it now forbids it, in unexplainable contrast to title 18.

All details of the recommended formulas, specific as to percentages and amounts are presented to you today as exhibit 3.

We have had the generous help of one of the best health insurance actuarial teams in the country. We are satisfied now that each concept employed in these amendments contributes in an essential manner to the objective of bringing adequate health care within the reasonable reach of all of our people.

We believe that the omission of any concept will result, not only in an unbearable present cost, but of even greater concern, the most powerful available force countering the steepening rise in medical costs will be lost. It is an obligation of our legislative representatives to preserve this force.

We are told by our actuaries that medicaid in New York State may be expected to cost \$800 million a year above private plan benefits, presuming them to all remain in force. These same authorities find that these amendments should reduce the above figures by \$225 to \$250 million per year, dropping the medicaid cost to somewhere between \$550 to \$575 million.

There is currently a strong top-level attempt in New York State to force compulsory health insurance to bring down the cost of medicaid. Compulsory insurance, overlaid by medical in its present form will do nothing toward reducing cost. It would only redistribute it, and hide a portion from taxpayer view.

But the saving of \$250 million by our proposed amendments is true gain—arising from curtailment of overuse and pressure of interested users on medical personnel and facilities.

One important facet remains. We need a Connecticut or New York "65" type of plan, to be made available to all people at all ages who are not eligible for now existing private plans.

Insurance companies will respond with the creation of such a plan, if permissive legislation is passed. Thus, the desire of anyone who wants to be insured will be met. The very small number who may not so choose, should not be bailed out by public funds until they have spent their own funds up to the threshold of a truly impossible burden.

Society's obligation does not commence sooner for those who choose not to protect themselves.

Mr. ROBINSON. There is a basic philosophy in here, gentlemen, which I hope we are getting across to you. That is one of relieving an individual's anxiety over major medical costs, but by no means his entire responsibility.

By no stretch of the imagination should we relieve that man of his responsibility to help provide for his own good health.

We have read recently with some consternation the recommendation by Secretary Gardner that model State laws could require—underlining the the word require—comprehensive health insurance; in other words, a compulsory plan.

We are currently fighting this issue right now in our own State for reasons shown in exhibit III, and one world of amendment on that.

We couldn't get the aircraft off the ground yesterday so I was unable to deliver that presentation to the joint legislative committee, although it was scheduled yesterday—I will do so on the 13th—of New York State.

Frankly, this concept of compulsory insurance in New York State is in reality, and has been almost admitted, a desperate effort by the State government to remove some of the cost of Medicaid from the general revenue fund.

Labor, industry, and John Q. Citizen have spoken against this. Health insurance is a personal privilege to have or not to have as one sees fit. It is a benefit won by labor through long hours on the picket line, and if coverage and premiums are mandated by law their ability to negotiate is relegated to a lobbyist.

Any move toward mandating such coverage with all of the governmental controls which are historically in such a program truly establishes a national health coverage.

Now, I think you see that our amendments encourage adequate insurance coverage, but the type and amount of coverage is an individual privilege. We feel both on a State and Federal basis that more than just stopgap measures are required in the field of public health.

There are many overlapping and conflicting Federal programs which could be brought together into one sound, cohesive plan, sensibly and economically administered. If this is done, along with responsible revisions in title XIX, there won't be the need of compulsory health insurance, which very honestly we in New York State refer to as the "medicaid tax."

A tax by any other name is still a tax, and, gentlemen, we feel government, both State and Federal, owes an equal responsibility to the taxpayer as well as to the needy.

The amending plan shown in exhibit III was presented to members of the New York State Joint Legislative Committee on Problems of Public Health and Medicare last Wednesday.

Our attorney, Mr. Cohen, and his staff are committed to putting this plan in legal form for delivery to the legislature by March 15. We are widely supported across the State in our efforts to have these amendments passed at this session. The political realities are ever-present.

Unless the men who control our State government are forced into a reappraisal of New York's medicaid plan by congressional limitations, I am afraid there is little chance of passage this year. Right now these gentlemen need an avenue for "saving face."

It is hoped that the cost to the State next year, which will be astronomical, will push our legislature into a rebellion and result in substantial changes.

We are hopeful that you will adopt the philosophy of our amending proposals. Then you can concentrate your efforts and your funds on the improvement of our medical facilities—make them more viable, efficient, better staffed, better trained, better equipped.

Free services do not guarantee good health. It is the old adage that you can lead a horse to water. Educate our people toward better health standards, but don't open the door of our medical facilities to abuse and don't allow for the degradation of our medical profession.

Now, there is a facet which I have not covered. At the last moment we found Dr. Sullivan could come down here, but he has some pertinent words concerning the critical aspect of a doctor-patient relationship which suffers under programs of this nature.

Dr. Sullivan.

The CHAIRMAN. Dr. Sullivan, you are recognized, sir.

STATEMENT OF DR. THOMAS H. SULLIVAN, MEMBER, BOARD OF DIRECTORS, CITIZENS COMMITTEE FOR RESPONSIBLE GOVERNMENT

Dr. SULLIVAN. Thank you, sir.

Mr. Chairman, gentlemen, I am a dentist from Syracuse, N.Y. I am speaking as a citizen, a doctor, and a member of our committee here.

Each working day from, oh, 8 in the morning to 6, 6:30 in the evening, I treat patients. It is essential, therefore, that I establish what is known as a patient-doctor relationship.

I will speak, then, of the importance of this relationship to good medicine for our people and the adverse effect that a widespread dole system would have upon it.

You and I know Americans enjoy the finest medical service the world has ever known. True, our great endeavors in research and education are responsible in part for this. But largely responsible also is the patient-doctor relationship engendered by our free, competitive system, as we know it in medicine today.

In addition to motivation by desire to aid fellow men and excel in his tasks, the good doctor realizes his patient must be satisfied. If the doctor does not make the effort to create a desirable relationship while at the same time rendering excellent treatment, the patient will find a competitor, another doctor who is capable of these things.

My colleagues in dentistry, medicine, and the allied fields may be professional men, but if they are to succeed they must perfect themselves or be lost in the ever-continuing battle of competition.

Under such a competitive system, there exists the greatest motivation for self-improvement which results in improvement of patient care.

We all know that when any segment of our life comes under the welfare or dole system, efficiency and quality suffer. This is historically true. Is it not sad, therefore, that we chose to begin this system with something so important to our people as their health?

Some may say we are not socializing health in this country, we are merely helping the "medically needy." But I submit to you that in my State, the State of New York, it has been decreed that 40 percent of the people are medically needy and therefore qualify for completely free medical and dental care.

And this, gentlemen, is in one of the most prosperous States of the most prosperous country in the most prosperous time this world has ever known.

Gentlemen, it is obvious to all and especially to those of us who work daily with human misery that the truly needy must be aided. This need overrides even this adverse effect on patient-doctor relationships.

But it would be catastrophic to the ultimate health care of all our people. Even a dole system is not confined rigidly to the truly needy.

It is my considered opinion that the health of our Nation is one of our foremost assets and in conjunction with that, as doctors under a competitive system, we try harder. Thank you.

Mr. ROBINSON. In summary, gentlemen, we ask this. Let us have a medical assistance plan for needy people, but not a supplemental income plan. Legislation which promotes an individual's reliance upon a State organ is not progress; this is truly regression, and we urge legislation which will promote individual responsibility in this area.

Once again, we thank you very much for this opportunity.

The CHAIRMAN. We thank you, gentlemen, all of you, Mr. Robinson, Mr. Cohen, Mr. Newton, and Dr. Sullivan, for coming to the committee.

You have material here that you have not used and I am going to suggest, Mr. Robinson, that you work with some member of our staff as to what will be included in the record. Some of it is not for purposes of the record. I am sure you do not intend it to be.

But without objection, those parts will be included in the record that have to do with the situation in New York.

Mr. ROBINSON. All right, sir.

The CHAIRMAN. Any questions of these gentlemen?

Thank you very much.

Mr. ROBINSON. Thank you, sir.

(The material referred to follows:)

EXHIBIT I

STATEMENT OF CITIZENS COMMITTEE FOR RESPONSIBLE GOVERNMENT, MANLIUS, N.Y.—EXHIBIT TO COMMENTARY BY MR. JOHN ROBINSON, JR.

Gentlemen, on behalf of the members of our Committee and the thousands of people who have worked with us these last 10 months, allow me to express our appreciation for this opportunity to share our thoughts on New York State's implementation of Title XIX, to the Social Security Act of 1965. We hope you gentlemen will be interested in hearing the "other side of the coin," so to speak, since our state's administration has lost no opportunity to fulfill federal support of New York's program. Indeed, we have suggested that our Governor apply for disaster area funds instead, since he feels that about half our state's population are indigent. We believe that is a somewhat higher percentage than found in most sections of our country.

At this juncture we feel a few brief words of introduction are required. I am John J. Robinson, Jr., State Chairman of the Citizens Committee for Responsible Government. With me today is Mr. Leslie H. Cohen, our counsel, and Mr. Donald C. Newton and Dr. Thomas H. Sullivan, members of our Board of Directors. We are all private citizens who have devoted more than our spare time to a continued study of what is locally known as Medicaid. We have conducted unceasing effort to realize a more sensible program. Let me assure you that none of us are seeking elective office or political appointment, nor are we attacking or defending any given political party or philosophy; Our membership consists of all. Since May 24th, 1966 we have spoken to hundreds of groups and organizations, involving thousands of people from all walks of life from across the entire state and we can categorically say that we truly represent the vast number of people in New York State who are totally dissatisfied with the current New York Medicaid program.

As a committee we are not seeking to deny medical assistance to any truly needy person—we favor and support such assistance. But, we are seeking to prevent the financial and moral bankruptcy of the State of New York and its citizens. Of great concern to us is that the current medicaid program has proven to be so burdensome, both administratively and financially, that the entire con-

cept of medical assistance for needy people will be discarded by an irate citizenry, both on a state and federal level, as happened in the State of Washington some years ago. In New York State, at the present time, our citizens are even more upset than they were when the program was first implemented last May, a more thorough understanding of the plan and the manner of its passage, as well as our experiences to date. The Medical Society says the program is bogged down in red tape, which indeed it is, and that this will get worse, not better. County officers are concerned about the administrative problems as well as the unresolved financial burden on local property taxpayers. All of us as citizens are concerned about the sudden moral impact of non-responsibility as well as the extreme state and county tax burden imposed. As the people, who can well afford the majority of their own medical bills, come to the public trough for free services, they readily use up the available monies. Thus, those persons truly in need find a great deal of reticence on the part of the Welfare Department not only authorizing needed medical treatment, but in actually processing the application for Medicaid Credit Cards. This has been particularly evident these past few months. At the same time the callous disrespect evidenced by the public for anything free has resulted in overcrowding and abuse of existing medical facilities. This too, has happened in New York State albeit firmly denied by any State official. Not only does proper care become a problem under our existing State plan, but we are severely hampering other existing plans. As an example, members of the Department of Health have privately complained that they cannot get the newborn child immunization program rolling because their department is over-extended taking care of Medicaid. There is a limit to what money and people can do and New York State has reached that limit, shortly to go beyond, unless something is done, and done now.

Now, of course, you gentlemen are fully aware that all of this is your fault; we have been told this time and time again by the State's administrative and legislative leaders. You caused all of this to happen when you originally passed Title XIX. Should we mention our Senate Minority leader's statement at this point; last June when he turned to some legislative critics and told them to tell their newspapers that this (the State plan) was a shrewd piece of business, that the federal money was there and we're going to get our share first. But, that couldn't have had any effect on the passage of the New York Medicaid program . . . no, gentlemen, according to the State it all falls back in our laps with Title XIX. According to our Governor, New York State was deliriously happy with providing a rather liberal and comprehensive program of medical assistance for needy people under the Kerr-Mills legislation. Then along came Title XIX and New York had to go to great extremes just to comply with the federal law in order that we could continue getting our fair share of the Federal funds. When we criticized the raising of the eligibility levels we were told this must be done to comply with section 1903, paragraph e. When we said, all right, raise them if you must. But, from \$4700 to \$6000 net for the family of four we were told there was another section that stated the states must spend as much for medical assistance under Title XIX as they had in the past, and to do this we had to cover more people to spend the money. In other words, we, as a state, had no choice but to go to these extremes to comply with the federal law. Yet, if you will look at the charts in front of you, you will see refutation of this via published figures from the Governor's office, released to the public press.

Chart 1 shows where our state and local communities spent less in 1966 than in 1965, \$100,000,000 less, and yet cared for more people. Somewhat incredulous to believe and also contrary to what we were told must be. Chart 2 is an exact copy of the figures given us by the Governor at the May Joint Legislative Committee hearings. The 1965 figures were substantiated as the actual costs of our 1965 medical assistance program—also shown is the 1966 budget which had obviously been passed by them. Yet on Chart 1 the Governor is telling us that he not only spent less in 1966 than he budgeted, but less than he spent in 1965. Gentlemen, to date we have been unable to get clarification of these figures and can only assume with some degree of certainty that entire areas of federal and state spending were left out of the 1966 expenditure report. This is substantiated somewhat by the fact that at the time the \$350,000,000 cost figures were released the Governor submitted a supplemental budget to the legislature asking for an additional \$39,300,000 to cover extra expenses incurred by the Medicaid program.

We are not offering these figures in an effort to embarrass anyone but rather to ask that you gentlemen do not allow yourselves to be seduced by low cost

or user estimate. Indeed, we ask that your auditors make a complete investigation of all costs incurred to date, not just fiscally. We know, for instance, that Herkimer County's medical costs alone in December 1966 were more than the entire welfare expenditures for that County the previous month, November.

You gentlemen must know how much money was reimbursed New York State by the federal treasury, and we are sure you are well aware this amount is only a starter. Our Welfare Department's new schedule of hospital payments, retroactive to July 1st, is up 38%—their schedule of doctor fees is up about 75%. New York City, by its own admission, has not even begun to get the program rolling. In fact, the Office of Economic Opportunity has hired people in New York City to conduct a door-to-door campaign with the express purpose of signing people up for Medicaid, while other counties have purposely held back the processing of applications in a desperate attempt to make their 1966 budgets stretch through the year; and this is tragic because we saw case after case of people truly in need unable to get the assistance they truly deserved. There is a tremendous backlog of bills from 1966, unprocessed due to insufficient staffs which must be paid in 1967 and which actually distort the true cost picture of 1966. 21 hospitals in the State were forced to borrow money last year in order to meet their daily expenses due to the inability of the Welfare Department to process their vouchers, regardless of Commissioner Wyman's claims to the contrary. If you wish verification of this we refer you to the Hospital Association of New York State, Albany. As a matter of fact, legislation has been introduced in the Legislature expressly designed to speed up these payments.

This is part of what has been happening to us, gentlemen, and it will be worse next year. Governor Rockefeller has announced that as many as 2,900,000 people will use the plan in 1967, yet figures we received from individually Welfare districts show that without a doubt we will start the 1967-1968 fiscal year with at least that many, and any implementing county can show you that applications are still coming in at the rate of $\frac{1}{4}$ of 1% of the counties' population per week. Of course, the State says that only 25% of the people who have had their cards will get sick in any one year, and they literally seem to base their budgets on this. This is too ludicrous to comment upon except to say that one need not get sick in order to have their teeth cleaned, eyes checked, flu shots, drugs, etc. Here again we have a classic contradiction by the State. A much heralded reason for the the Medicaid program was that it would allow people to have preventive medicine; in other words, treat them before they become sick and, thence, dependent upon the State. We say, and I defy contradiction, that families with the Medicaid card will use it whenever and wherever they have occasion to; after all, it's much easier to charge a bill than lay out cold cash.

We hope you are able to unscramble the State's figures, for your own sakes, in order that you can assure yourselves that the expert actuarial reports submitted by us last summer and substantiated by Mr. Robert Meyer will, and are, rapidly coming true. Figures returned to us via our questionnaire by about half the Welfare districts in the State show that the average budget increase of 1967 over 1966 was 76%. Based on this and the increase in users, we conservatively estimate the total expenditure in New York State for the fiscal year 1967-1968 will exceed \$850,000,000 unless New York City gets rolling sooner than anticipated; of this your share will approximate \$320,000,000. By the fiscal year 1968-69 the users will be well over 5,000,000 in number, the total expenditure \$1,300,000,000 and the federal share approximately \$500,000,000—and the total expenditure will continue to climb in this fashion. That our State government is aware that figures they once called "wild" are rapidly coming true is apparent in the current legislative moves.

We have heard members of the administration claim that various Welfare districts are using Medicaid as a whipping boy to get more money for their Departments. Our talks with the district Welfare commissioners, some of whom are financial contributors to our Committee, have been private and candid. Believe it or not, they are quite concerned about holding down costs as much as possible, although we have heard of one case where the county did raise its budget to a very high figure in order to embarrass some persons due to an inner-party squabble. This is just hearsay, although we have purposely left that county out of our averages. If anything, gentlemen, the county budgets for 1967 were purposely kept low because they were submitted during the Fall of 1966 when the election campaigns were in full swing. This was done to avoid political embarrassment, particularly in the larger counties, and I am certain, if

you spoke privately with these Welfare commissioners, you would find that they are deeply concerned about running out of money long before the fiscal year is over.

I trust I am not dwelling overlong on the subject of costs but they are important and, not knowing what information you gentlemen have received to date, we wish to emphasize the undue cost that has been thrust not only on the people of New York State, but on the nation as a whole due to federal reimbursement to the State. And these costs may very well climb more sharply than we anticipate. Recently, Mr. Chesebro, Deputy Commissioner of the State Welfare Department, said "We are moving in a direction in which every citizen will be entitled to the health care he needs whether he can pay for it or not."

State Welfare Commissioner Wyman has already stated that he will ask for higher eligibility levels due to the erosion of inflation taking away much of the gain achieved when the levels were increased from \$4700 to \$6000 net. Our committee is well aware that a considerable amount of pressure has been exerted from the outset to have the base level for the family of four made \$8800 net income per year. How many this would add to the eligibility roles we cannot estimate. Please bear in mind that under State Law Commissioner Wyman need not ask legislative approval for any increases; the legislative act does not set the levels or guidelines for their establishment. All that is required is approval by the Board of Social Welfare and the entire population of New York State could be placed on the Welfare rolls for medical assistance, thrusting an even greater burden on the state and federal coffers. We feel that this alone is justification for federal limitations. It should be required that the state legislatures set these levels in order that the power of taxation is not transferred to a non-elected body.

When you really analyze Medicaid in New York State you can readily see that is not a plan of medical assistance for needy people, but rather a State subsidization of a way of life—a supplementary income plan if you will. This is best shown in statements made by Mr. Hugh Jones, Chairman of the Board of Social Welfare, in testimony at the May Joint Legislative Committee hearings. Mr. Jones, in defending the Board's adoption of the \$6000 eligibility level, gave the following minimum subsistence budget, as developed by the home economists of the Department of Social Welfare, as it pertains to a family of four:

	<i>Per year</i>
Rent and heat, \$88 per month-----	\$1,062
Utilities, \$12 per month-----	144
Food, \$28 per week-----	1,456
Clothing, cleaning, \$11.60 per week-----	603
Drugs, cosmetics, \$2.65 per week-----	138
Recreation, \$4 per week-----	208
Total -----	3,612

While we agree this is a minimal budget, please note that it leaves our \$6000 per year family of four \$200 per month after taxes to spend as it pleases. Mr. Jones alluded to this surplus when he said we must realize these people get caught up in our credit economy—that installment buying of washing machines, automobiles, etc. quite often leaves these people without sufficient funds to pay for medical services. Thus, approximately 44% of our State's population was given an income supplement of an undetermined and unlimited amount, and at the same time, freed of any personal responsibility to provide any form what-so-ever of medical care for themselves or their families. If a supplementary income plan was the Congressional intent during passage of Title XIX we would greatly appreciate an announcement to this effect.

I wish we could tell you that our State government, aware of all these facts and problems, are taking steps to correct the situation, but I cannot. The Joint Legislative Committee, set up expressly for the purpose of reviewing this program, has not held any additional hearing since last May. I think you should be aware that when Mr. Folsom spoke at that hearing and urged a temporary halt in the implementation until a full review could be made, the chairman pounded the table and stated we couldn't because for every month we delayed, we lost something like \$8,000,000 in federal money. Right now, rather than review the current program, legislation mandating compulsory health insurance has

been introduced in what has been admitted as a method of removing some of the costs from the tax roles and spreading it around somewhat. This, without revisions in Medicaid, would truly give us a State health service; Mr. Newton will speak about this.

Actually, on two separate occasions we have received a lecture from a member of this same Joint Legislative Committee concerning the dangers of people coming to Washington to ask for changes in Title XIX. We received the full motherhood treatment but retorted that quite honestly we feel that what happens in New York State affects the entire country; that if we felt there was even a remote chance for responsible action on the part of the State Government, we would not have need of your help. And, gentlemen, we, and the entire nation, need your help in this matter. There have been many suggestions made for limitations to the federal participation in the New York State plan—I am sure, made by people far more knowledgeable in the workings of government than our Committee. We urge that you act without hesitation, even though knowing full well we, the citizens of New York State, will have to make up the difference, at least for a while. We urge that you treat New York State just as you would any child who tried to take too many cookies from the cookie jar. Please, look around you and see what has happened to every program where the philosophy of "a helping hand" has been replaced by the philosophy of "this is your right," which is what we now have in New York. Our program of medical assistance is not "the greatest piece of social legislation ever passed" * * * it is not progress, but actually a giant step backwards * * * instead of striving to make the individual self-supporting we are forcing an even greater reliance by him upon the State.

We feel that you can and must effectively limit the federal participation in this program, without resorting to any complicated formulas, by insisting that the Federal Government will participate in a full range of medical services only for those people totally dependent upon the State for their everyday subsistence. You can also relieve the states and local communities of the "prior monies spent" onus, or, if you wish, insist upon the same amount of money spent as a minimum and you will participate in the balance until such time as, due to population increases and rising costs, you arrive at the sharing basis described in Title XIX. We support the views as expressed by Mr. Thomas Curtis as put forth in House Report 2224 and urge that a form of catastrophic insurance be made available to the States in order that we can aid and assist those in dire need from having them become completely dependent upon the State due to extreme financial expenditures. In this area provisions for deductibles and co-insurance should be made available in all areas of federal participation. Mr. Newton will describe amendments we have planned to introduce to the legislature this year—their success depends a great deal upon what you gentlemen do with Title XIX in the immediate future. At this time our Committee is in the process of drumming up active support from organizations across the State—we are in touch with Labor, Manufacturing, Medical, County Officers, Legislators, etc. This will be an all-out, concentrated effort to have our amendments passed this session. But, practicalities have the upper hand and unless the two men who presently control the State's destiny (I refer, of course, to Speaker Travia and Governor Rockefeller) are forced into a reappraisal of the enormity of our problem by Federal limitations, it is highly doubtful that our amendments will ever hit the floor.

We are in an exceedingly difficult position—it has become painfully apparent over the last 9 months that very few of the State's political leaders had a full comprehension of what the State had done in the past and what the new Medicaid program would do. These men have been backed into a corner from which, in their minds, and maybe rightly so, there is no retreat, so the only course left open is praise and a possible subtle shift in some other aspects. We have been told, on a confidential basis that the Health Department will take over most or all of the functions of the program. Our mandatory group insurance is another move designed to relieve and prevent further embarrassment over costs. The Governor's latest dance with cost figures shows his mounting concern. So we are thrown into a situation of "saving face." We have been leaked the word that no matter how many people in the State of New York demand changes in the law, nothing will be done unless the federal government forces the State to revise its program.

There are two areas open here. One is, of course, your amendments legislative, restricting the States, and we deem this the best approach—the other lies

in section 1902, paragraph 7. Herein lies the wording "reasonable standards of eligibility", and there is no reason whatsoever that the Department of Health, Education and Welfare could not turn down further reimbursements of New York State because the eligibility standards are unreasonable.

According to Mr. Wyman's testimony at the May Joint Legislative Committee hearings, there were absolutely no discussions whatsoever with the Department of Health, Education and Welfare concerning eligibility levels. Yet, we have felt all along that some small effort on the part of New York State could have resulted in a sensible, legal lowering the present levels of eligibility. These areas are for you gentlemen to decide upon.

The answer to improving the public health lies not in making medical services and facilities free for all to use as they wish. One statistic we've heard quite often is that 95% of the children of low income families have never seen a dentist when they start school. We don't disagree with this fact of all and consider it as deplorable as the "bleeding hearts" do. But, free services won't help that child. When the child hands his parents the note from the school saying Johnny has ten cavities, the parent is just as liable to say "so what, I've had cavities all my life" and the note hits the round file. Education is the key factor here—educate that child to good health—his parents are possibly beyond redemption.

The federal government has several such programs already under way. Gather them together in order that you can do a first class job, economically, and educate the children so that as they reach adulthood it automatically becomes part of their nature to maintain good health standards. If you really want to spend more money in the field of health, we feel this is an excellent area for it. Also, take some pity on our hospitals—relieve them of all the blasted paper they must process today—make funds available to them for capital expenditure on buildings, equipment, staff training—in other words, help provide the facilities if you must, but place the responsibility for the use and quality of these facilities on the shoulders of the users because, unless the people respect medicine, they will abuse it, and overall quality of medicine then will deteriorate. We feel also, that it must be remembered by all levels of government that an equal responsibility is owed to the taxpayer as well as the needy.

Gentlemen, I thank you, and now, with your forbearance, Mr. Newton will speak about our amendments and the insurance side of this picture.

EXHIBIT 11

REMARKS BY JOHN J. ROBINSON, JR., STATE CHAIRMAN, CITIZENS COMMITTEE FOR RESPONSIBLE GOVERNMENT ON HEARING ON COMPULSORY HEALTH INSURANCE

(Joint Legislative Committee on Problems of Public Health and Medicare, Albany, N.Y.; March 6, 1967)

Mr. Chairman, Gentlemen, I am John Robinson, State Chairman of the Citizens Committee for Responsible Government. The issue before us today is truly of great import; but this issue is not whether we shall or shall not have compulsory health insurance, nor if we do, what the coverage, limits, and premiums shall be. Today's issue is just one basic question: Shall our State provide a comprehensive program of medical assistance for needy people or shall it institute a State health service. Think for just a moment, gentlemen—in our discussions here today we are honestly trying to upgrade the medical care of our needy people by mandating health insurance coverage, or are we instituting a State health service as the end result of such insurance coupled with the current Medicaid program. This is a question each one of us must answer, now.

If we are to have a program of medical assistance for needy people, then let us institute one before this legislative session ends, since the current Medicaid program is not medical assistance for needy people, but it is a supplemental income plan of an indeterminate and unlimited amount. If we are to have a State health program, then let us start anew and build from the ground up, and after doing a thorough job for a change, offer it to the voting public via referendum. Let us not make a State health plan a matter of law as the result of desperate scrambling by members of the State government to avoid further embarrassment over last April's fiasco.

At present we stand in great danger of destroying the entire concept of medical assistance for needy people due to an increasingly heavy administrative and financial burden. People and a tax structure can stand just so much. This far reaching implication can affect people across the nation, not just New York. Very frankly, I for one am tired of our State being the laughing stock of the nation—we have incurred the wrath of our sister States and the Federal government.

As a state we have wreaked absolute havoc with the noble and charitable concept of medical assistance for needy people. Our committee feels it is high time for the legislature to assert itself as an independent law-making body, truly the representative of the citizens of this State. We ask that you overrule the intemperate attitude shown by some members of our government when they say—the public be hanged—there will be no changes in Medicaid.

This present dodge, compulsory health insurance, being foisted off as preserving and extending a vital resource is virtually the straw to break the camel's back. Lest anyone develop the wrong opinion, this legislation, if passed, will not reap a harvest of dollars for the health insurance industry, but will drive it right to the Wall. Our committee is tired of half-way stop-gap movements that only lead to more and bigger problems in the immediate future. We are asking for an honest, earnest effort to get our State and it's people out of the trouble we are in.

Yet, I guess a legislation such as this is what we should expect—it's certainly in line with what we are told these days. We haven't heard the administrative branch of our government give realistic or consistent cost figures yet. It would like to know how, last May, in front of this same committee we could be shown charts giving 1965 Medical Assistance costs as \$449,000,000 a 1966 Medicaid budget of \$532,000,000, then be told the cost of Medicaid for 1966 is only \$350,000,000, plus a \$39,000,000 deficit.

Something, somewhere is haywire, and now we are expected to believe that the mandatory health insurance will save the wage earner \$44,000,000—cost industry an additional \$145,000,000—yet deduct \$210,000,000 from the cost of Medicaid. . . . This doesn't add up either—where does the other \$109,000,000 come from or has the insurance industry decided to donate this amount.

Possibly we should not question these figures, but we feel it high time the citizens and taxpayers get some honest information as to just what these programs cost. You might say we in New York have our own credibility gap. After all, we are the ones paying for it with every hour we work.

I think we should call compulsory health insurance by its proper name—Medicaid Tax. Let's not go back to the fee is a fee, and not a tax routine. Let's be honest and admit that with Medicaid unchanged, compulsory health insurance is a frantic scramble on the part of the State government to spread the costs of Medicaid into other areas and get it out of the State's budget.

Yes, rather than face reality, let's tax the wage earner an additional 2% whether he wants it or not. Rather than revise Medicaid into a sound program, let's slap a new tax on industry, an additional \$145,000,000 a year to start, rather than admit we might have erred some little bit last April. I have heard this plan will be held to a minimum such as the existing Workmen's Compensation Plan, but each one of us in this room today knows that as the costs of Medicaid climb, more and larger areas of coverage will be forced into the private carrier, the individual and industry, on a continuing basis so that our State budget won't suffer as a result of our State health plan. But it is still a tax.

Can you possibly justify such a move and keep this burden on the entire population of this State? Must you open another Pandora's box under the guise of covering a small percentage of our population? Can you ignore the right of labor to negotiate it's own contracts of coverage and will you relegate this right, won by hours on the picket line, to a lobbyist? Do you honestly feel justified in placing the enormous burden of Medicaid on the backs of industry, just to save political face? Can you impose socialized medicine upon the citizens of this State—socialized medicine with all of its attendant woes and degradation of the medical profession, without the citizen's approval?

Will you do all of this as the result of your original legislative act designed to implement the federal government's proposal to upgrade the quality of medical care provided our indigent; or is our State government running scared because the cost estimate they once called "wild" is coming true, and it is now

realized that people undoubtedly will drop their health insurance once they become assured that there will be no changes in the Medicaid program. After all, why pay twice for the same services.

We trust you gentlemen will get the answers to these questions we are raising; and answered they must be, as well as our question for today—medical assistance for needy people or State health service.

If you gentlemen have analyzed any of the statements made by the Citizens Committee for Responsible Government in the past ten months, you have found we feel a main fault with the bill you passed last April lies in that you gave away every bit of your inherent power to regulate the tax, and we have asked that you take back these powers. This concept of government by expediency, government by administrative edict is an extremely dangerous form of government. These administrators are immune in every way from the will of the people—even the courts have steadfastly refused to review their actions and if we have properly analyzed this Medicaid tax bill, it provides a stronger base for complete and dictatorial control of medicine, as well as insurance. I quote the February 22nd handout; "the Department of Health would supervise the hospital standards and charges, etc. . . . the Insurance Department would regulate premium rates, etc. . . ."

The passage of this legislation would once again give complete unlimited control to agencies who are immune to the desires of the citizens of this State. Now these administrative decisions have the weight of law; yet the legislature, the voice of the citizen, is supposed to be the law-making body, not an administrator. A classic example is the administrative edict which mandates billing by medicine of the welfare departments, not the individual. This has caused a great deal of furor within medical circles; yet it is only a decision—but it has the weight of law because no one can challenge that decision.

Right now the legislature is considering a review board for an administrative department so you are aware these problems exist—yet the Medicaid tax bill would turn around and once again give unbridled authority to three separate departments. For this reason alone our committee would oppose this legislation. A while ago I referred to our current Medicaid program as a supplemental income plan. Let me illustrate, if you will, by going back to May's hearing by this committee when Mr. Hugh Jones put forth a budget for our magical family of four. It was upon this budget that, theoretically, the \$6000 eligibility level was established. After providing for food, rent, heat, utilities, clothing, miscellaneous needs and recreation, this budget, surprisingly, only totaled \$3612 per year. Now I will agree this is minimal but we must realize it leaves our \$6000 a year family \$200 per month to spend as they please. I believe Mr. Jones alluded to this surplus when he stated "there are now these nagging expenditures of a family that can catch up with it, the time payments and the installment payments and the obligations which they have underaken".

So, gentlemen, as the result of a plan based on vague legislation, we then instituted a supplemental income plan of an indeterminate and unlimited amount to help take care of "these nagging expenditures" by removing any possible individual responsibility for medical expense. All under the guise of medical assistance for needy people. This supplemental income plan can be expanded at will by an administrative body who can legally set any eligibility level it so chooses, without the Legislature's consent. Commissioner Wyman has already stated he will ask that these levels be raised when he deems it necessary. And now, it is the wish of our State government to compound this issue with Compulsory insurance—to finance this supplemental income plan by imposing a Medicaid tax upon us all.

Gentlemen, all of this is not progress, this is regression. Whereas every governmental program of this nature is theoretically aimed at helping the individual become self-sufficient, it seems our every effort in the field of medical assistance is aimed at making the individual more dependent upon the largess of a State administration, aimed at destroying his responsibility and incentive.

We are as aware as anyone of the provisions in Title XIX used to throw the blame for this entire mess back into the laps of the Federal government. We intend to dwell heavily upon these with the House Ways and Means Committee Wednesday. Yet, somehow, we feel even the slightest effort last spring on the part of New York State would have resulted in a federal OK to keep our program of medical assistance within the bounds of good common sense.

Let's have that effort now. The current medicaid program is so disliked, so hopelessly snarled in its administration, that we cannot understand nor accept the fact that corrective action is not being taken at this time.

Why, your original legislative concepts are being destroyed. I am not going to enter into the problem areas of medicaid—I trust a number of welfare commissioners will speak at these hearings—I trust that this time you will receive them in a gentlemanly fashion and listen to what they have to say, because they have first hand knowledge of the problems we are faced with.

Gentlemen, this is not a time for party politics or divergent personalities. This is not a time for protecting images or political aspirations. But this is a time to decide between a State health plan or a plan of medical assistance for needy people. It is a time for all of us to sit down, forget past differences and act.

You have before your committee amendments drawn by the Citizens Committee for Responsible Government with the help of some of the foremost experts in this nation. Amendments designed to provide medical assistance for those who are truly indigent, as well as those who are needy due to catastrophic costs. Amendments which will relieve the anxiety of the individual over large medical expenses but not his responsibility. We urge that you act on these amendments. We urge that you refute this farcial face saving attempt, this medicaid tax and that you take back your inherent powers.

Provide the people of this State with a legislative, not administrative, plan of medical assistance for needy people we can all accept and support. We urge that you recognize the State has at least an equal responsibility to industry and the taxpayer as well as the needy.

Let's return to Progress.

EXHIBIT III

CITIZENS COMMITTEE FOR RESPONSIBLE GOVERNMENT PROPOSED AMENDMENTS TO NEW YORK STATE MEDICAID

People on welfare have all their medical bills paid for them in full as a part of welfare support. This full payment is of course necessary for people who are dependent on the State for their living expenses.

We do not oppose this. In fact, medical care for these people should be made more adequate, and we will support increase in this area of public cost if it is soundly and economically used to improve medical care of welfare clients.

But, we firmly oppose payment from public funds of the entire medical costs of anyone not on welfare. Medicaid now does just this. It pays the routine and incidental expenses of people perfectly able to pay for themselves.

For any person who is not on welfare we urge that the use of public money be limited to those medical expenses which lie beyond his reasonable ability to pay for himself from income, personal resources and insurance.

The result of this limitation will be to stop the great waste of public funds in paying routine costs and eliminate also the extraordinary administrative expenses made necessary by the multitude of small payments. Public money can then be concentrated and focused on the critical purpose of helping all citizens who are faced with sudden catastrophic expenses or heavy and long continuing costs of chronic illness.

This is our central concept—that as surely as social conscience demands that the true over-burden of medical costs be paid by public funds, public funds must be strictly confined to that over-burden or there simply will not be enough money available for this purpose. And we will have failed to adequately help those who need it most.

It is of transcendent importance to have adequate cost controls in this unique area of expense. Adequate medical care is the real objective—perfect medical care is not possible, or yet even definable. Over-use by reasonable objective standards may take place without the user being aware of it—he is not objective. Abuse can be so subtle that much of it is impossible to root out. The cost of both is heavy and denies both money and facilities to meet pressing needs.

A person cannot be expected to refuse help which comes free when one crosses an eligibility line. In fact, there is overwhelming evidence that what is free is over-used.

There is only one way in which costs can be controlled and that is through the self interest of the user expressed in terms of economic motivation. Insurance companies have long since found this out and developed two types of control which have equal applicability for use by the State. There are no others available, except compulsion imposed on both the individual user and the personnel and facilities he uses. This we reject on deep philosophical grounds. Without the use of these proven controls the cost of Medicaid will rise steeply and uncontrollably. The State plan can no more avoid ultimate bankruptcy through the lack of them than can an insurance company.

These controls are of two sorts. One is known as a "deductible", the purpose of which is to avoid payment of whatever amount, for a given family, at a given income, may fairly be considered tolerable expenditure in any year's budget. As to the lower portions of this amount, medical expenses are as normal a demand on income as is food and clothing. The upper portion can be met by reasonable sacrifice and lessening of expenditures for commodities and pleasures which are flexibly included in any budget. It should be neither "insurable" nor "recoverable" from any public source.

When medical expenses rise above such an amount a family begins to be overburdened and will need help in paying them by resources in this order: first by self help in further adjusting of its budget—putting these expenses ahead of some desirable, but deferrable expense. Second, by buying insurance to protect themselves and finally, when the first resource would become overtaxed and the second has run out, by public aid. Throughout this range of expense the family should be adequately assisted, but not "carried free".

In order that public funds be not involved except where private resources have been first used, there must be a strong stimulus towards making these private sources as adequate as possible. Income at a given moment is fixed, but the other resource, insurance, can be used to multiply many times over a family's ability to be self-sufficient. This translates into the necessity of making it economically worthwhile for a family to purchase as adequate personal health protection as possible.

And it means that, although public help must be had before real distress is present, it must be postponed to the outer limit of tolerance, rather than coming in early enough to erode the incentive to use private insurance as far as may be. We repeat our conviction that unless the involvement of public funds is thus limited, there will not be enough to provide adequate help for those whose needs is truly beyond their capacity to meet.

EXPLANATION OF PROPOSED DEDUCTIBLE

This is in two parts; both of them are applied annually (on calendar year basis) to medical expenses of entire family.

A. An amount related to income:

It should be based on the entire income received within the family by any of its members from all sources. This is the true income resource. We define it as it is found on line 9 of Form 1040. The amount of deductible should increase in proportion to income but, at any given income level, it should be less in relation to a larger family, than to a smaller one.

The amount of deductible should be sufficient to strongly influence the family to avoid or delay its impact through the purchase of private insurance.

To meet these specifications we suggest that the amount of deductible be equal to the Federal Income Tax for the family's specific income, computed on the assumptions of joint return and standard 10% deductions. This is within the limits of tolerance and provides a real incentive to recover the lower range of expenses through insurance. A person is motivated towards an adequate private plan because: (a) he will want to postpone the impact of the deductible as far into the future as possible with the hope of avoiding it entirely and (b) if and when he does encounter it, it will be reduced by whatever amount he himself pays in health insurance premiums.

B. The amount related to net worth: The second component of the deductible is based simply on the equitable fact that a person should involve his

assets to a marked extent before looking to public funds. But, he should not be forced to pauperize himself, or other vital social objectives are lost. Though a nominal amount of assets should be exempted from involvement, the provident person should not be forced to spend all that he has saved above that nominal amount in order to be equated with the improvident. Furthermore, there is no equitability in forcing families with certain types of assets to spend them while others possessed of equal quantities of different assets are protected from consuming them.

Thus, we define net worth, in very much the same way as it would be defined for purposes of securing a bank loan. The amount of this net worth which is protected from involvement is \$4,000 for head of household, plus \$1,000 for each dependent. An amount equal to 20% of assets above this exclusion constitutes a "net worth deductible" which is to be added to the income deductible.

We emphasize that we are not dictating (as does Medicaid presently) that any particular asset be actually spent. The manner in which a family meets this deductible is solely its concern. For example, a real estate mortgage be increased in lieu of selling investments or eroding a bank account designed for education. No doubt this net worth deductible does to some extent penalize thrift, but it does not entirely destroy the incentive to save as present Medicaid well may in many instances. (For detailed figures see Formula 1.)

EXPLANATION OF CO-INSURANCE

It is the chief function of co-insurance to keep the user constantly interested in holding down costs. To maintain this influence at higher income levels it is necessary that the higher the income the greater must be the portion of expense borne by the user. In this case there are two additional concerns, essential where public funds are involved. These concepts are applied in the accompanying Table Formula IIa.

(a) *As expenses mount the portion of them paid by the individual should decline.*—To implement this objective the total amount of expense (after the deductible is met) is broken down into "Units of Expense".

A "unit of expense" at any income level is equal to one-fifth of that income. Each successive unit of expense incurred by the family is reimbursed to a greater degree than the preceding unit. Thus, the heavier one's load, the less is the part of it he bears.

For example, a family with income of \$10,000 will be reimbursed 70% (\$1400) and itself pay 30% (\$600) of its first \$2,000 "unit of expense". If expenses continue through an additional \$2,000, it will be reimbursed 80% (\$1600) and itself pay 20% (\$400). The next unit is reimbursed at 90% (\$1800), and the family pays 10% (\$200). Thereafter, reimbursement is 100%.

(b) *There must be an economic incentive of real substance to motivate the user to first employ private insurance as far as it will go.*—Integrated with the concept in (A) on the preceding page, is a compelling incentive for a family to protect itself as far as possible with private insurance. Amounts recovered from private insurance are used in full as off-sets for both the individual's and the State's share of cost in relation to his first "unit of expense", then his second "unit of expense", etc. For example, a family illustrated in (a) with \$10,000 income encounters co-insured expenses. But, this family has private insurance from which it recovered \$5,000. \$2,000 of such recovery would entirely off-set the State's \$1400 and his \$600 cost in his first unit of co-insured expenses. The second \$2,000 of his private plan recovery would entirely off-set the State's \$1600 and his \$400 cost in his second unit of expense. The remaining \$1,000 of private plan recovery would off-set half the cost in his third unit of expense (the State's \$900 and his \$100). Thus, he has benefited to the extent of \$1100 by having a private plan that paid him \$5,000. But, because he had the private plan the State is relieved of \$3900 of cost.

We have had the generous help of one of the best health insurance actuarial teams in the country. We are satisfied now that each concept employed in these amendments contributes in an essential manner to the objective of bringing adequate health care within the reasonable reach of all of our people. We believe that the omission of any concept will result, not only in an unbearable present cost, but of even greater concern, the most powerful available force countering the steepening rise in medical costs will be lost. It is an obligation of our legislative to preserve this force.

We are told by our actuaries that Medicaid may be expected to cost \$800,000,000 a year above private plan benefits, presuming them to all remain in force. These same authorities find that these amendment should reduce the above figures by \$225,000,000 to \$250,000,000, dropping the Medicaid cost to \$550,000,000 to \$757,000,000.

MEDICAID AMENDED

FORMULA I.—Annual family deductible

[Computed on calendar year basis]

Total income of family (basis: line 9, form 1040)	Basis: Equal to Federal income tax, joint return, standard deduction— Number of exemptions			Percent FIT on top income (4 exempt)
	1	4	8	
\$5,000.....	603	306	1 25(0)	16
\$6,000.....	772	450	56	17
\$7,000.....	943	603	196	17
\$8,000.....	1,114	772	354	19
\$9,000.....	1,285	943	501	19
\$10,000.....	1,468	1,114	658	19
\$12,000.....	1,864	1,468	1,000	19
\$15,000.....	2,485	2,062	1,536	22
\$17,000.....	2,935	2,485	1,930	22
\$20,000.....	3,652	3,160	2,560	25
\$22,000.....	4,156	3,652	3,010	25
\$25,000.....	4,988	4,412	3,736	28
\$30,000.....	6,524	5,876	5,084	36
\$35,000.....	8,231	7,529	6,632	39
\$40,000.....	10,088	9,342	8,348	42
\$45,000.....	12,095	11,285	10,314	45
\$50,000.....	14,260	13,388	12,236	48
\$100,000.....	43,882	37,848	36,456	58

¹ Parenthetical figure is actual income tax. \$25 is minimum deductible under plan.

NOTE.—A. "Total Income of Family" is line 9, form 1040, amount(s) for all income received within the family.

B. For convenience of illustration deductibles are shown in reference to \$1,000 units of income. In operation the specific tax computation of Federal income tax would be made, on basis of joint return and standard deduction.

C. This deductible is a "corridor," that is, it is to be applied after benefits of any other insurance or prepayment plan run out. It may not be offset by either the deductible or the coinsured amounts under any other plan. Categories or items of expense which are excluded by other plans, but which are covered by Medicaid will count toward Medicaid deductible.

D. Health insurance premiums, to the amount paid by family members, will offset the deductible (down to its minimum of \$25).

An amount equal to 20 percent of a family's net worth above a certain excluded amount is to be added to the deductible determined by formula I.

Excluded amount:

For head of household	\$4,000
For each dependent	1,000

Net worth includes all assets such as bank accounts, securities, life insurance loan value, available value through mortgaging real property, automobiles, etc. It does not include value of household goods, clothing, etc.

NOTE.—This deductible amount, where it exists, is part of the "corridor" defined in note C.

FORMULA II.—*Coinsurance, basic table*

[Applied on calendar year basis]

	Percent paid by family toward 1st "unit of expense" ¹	Impact of percent paid by family ²
Total income of family—Line 9, form 1040:		
\$5,000.....	25	21
\$6,000.....	26	22
\$7,000.....	27	22
\$8,000.....	28	23
\$9,000.....	29	23
\$10,000.....	30	24
\$11,000.....	31	-----
\$12,000.....	32	25
\$13,000.....	33	-----
\$14,000.....	34	-----
\$15,000.....	35	27
\$16,000.....	36	-----
\$17,000.....	37	29
\$18,000.....	38	-----
\$19,000.....	39	-----
\$20,000.....	40	30
\$21,000.....	41	-----
\$22,000.....	42	31
\$23,000.....	43	-----
\$24,000.....	44	-----
\$25,000 ³	³ 45	32
\$30,000.....	50	32
\$35,000.....	55	33
\$40,000.....	60	35
\$45,000.....	65	36
\$50,000.....	70	36

¹ For any family "unit of expense" equals 20 percent of that family's "total income." If additional "unit of expense" is incurred lesser portion of expense is borne by family. See formula II (a).

² Percentage shown as "impact" is the percentage shown in middle column, adjusted by Federal income tax credit for tax-deductible medical costs. (New York State income tax credit is not included but would further reduce impact.)

³ Assume steady progression of 1 percent for each additional \$1,000 of total income.

Formula II(a).—Coinsurance, modified in proportion to increased medical expense applicable to coinsured expenses of family for calendar year

Total income of family	Unit of ex- pense ¹	Co-insur- ance, basic for- mula (per- cent)	Successive units of expense encountered in calendar year																Total paid by family
			1st paid by family		2nd paid by family		3rd paid by family		4th paid by family		5th paid by family		6th paid by family		7th paid by family		8th paid by family		
			Per- cent	Amount	Per- cent	Amount	Per- cent	Amount	Per- cent	Amount	Per- cent	Amount	Per- cent	Amount	Per- cent	Amount	Per- cent	Amount	
5,000	1,000	25	250	15	150	5	50	0										450	
6,000	1,200	26	312	16	192	6	72	0										576	
7,000	1,400	27	378	17	238	7	98	0										714	
8,000	1,600	28	448	18	288	8	128	0										864	
9,000	1,800	29	522	19	342	9	162	0										1,056	
10,000	2,000	30	600	20	400	10	200	0										1,200	
11,000	2,200	31	682	21	462	11	242	1	22	0								1,388	
12,000	2,400	32	768	22	528	12	288	2	48	0								1,632	
13,000	2,600	33	858	23	598	13	338	3	78	0								1,872	
14,000	2,800	34	952	24	672	14	392	4	112	0								2,128	
15,000	3,000	35	1,050	25	750	15	450	5	150	0								2,400	
16,000	3,200	36	1,152	26	828	16	508	6	180	0								2,650	
17,000	3,400	37	1,258	27	918	17	568	7	210	0								2,900	
18,000	3,600	38	1,368	28	1,008	18	628	8	240	0								3,150	
19,000	3,800	39	1,482	29	1,102	19	692	9	270	0								3,400	
20,000	4,000	40	1,600	30	1,200	20	750	10	300	0								3,650	
21,000	4,200	41	1,722	31	1,302	21	812	11	330	0								3,900	
22,000	4,400	42	1,848	32	1,408	22	878	12	360	0								4,150	
23,000	4,600	43	1,978	33	1,518	23	948	13	390	0								4,400	
24,000	4,800	44	2,112	34	1,632	24	1,022	14	420	0								4,650	
25,000	5,000	45	2,250	35	1,750	25	1,100	15	450	0								4,900	
26,000	5,200	46	2,392	36	1,872	26	1,182	16	480	0								5,150	
27,000	5,400	47	2,538	37	2,002	27	1,268	17	510	0								5,400	
28,000	5,600	48	2,688	38	2,138	28	1,358	18	540	0								5,650	
29,000	5,800	49	2,842	39	2,278	29	1,452	19	570	0								5,900	
30,000	6,000	50	3,000	40	2,400	30	1,550	20	600	0								6,150	
31,000	6,200	51	3,158	41	2,522	31	1,658	21	630	0								6,400	
32,000	6,400	52	3,318	42	2,648	32	1,768	22	660	0								6,650	
33,000	6,600	53	3,482	43	2,778	33	1,882	23	690	0								6,900	
34,000	6,800	54	3,650	44	2,910	34	2,002	24	720	0								7,150	
35,000	7,000	55	3,822	45	3,048	35	2,132	25	750	0								7,400	
36,000	7,200	56	4,000	46	3,180	36	2,268	26	780	0								7,650	
37,000	7,400	57	4,182	47	3,322	37	2,408	27	810	0								7,900	
38,000	7,600	58	4,368	48	3,468	38	2,558	28	840	0								8,150	
39,000	7,800	59	4,558	49	3,618	39	2,712	29	870	0								8,400	
40,000	8,000	60	4,800	50	4,000	40	3,000	30	900	0								8,650	
41,000	8,200	61	4,992	51	4,142	41	3,152	31	930	0								8,900	
42,000	8,400	62	5,190	52	4,290	42	3,308	32	960	0								9,150	
43,000	8,600	63	5,392	53	4,442	43	3,468	33	990	0								9,400	
44,000	8,800	64	5,598	54	4,598	44	3,638	34	1,020	0								9,650	
45,000	9,000	65	5,808	55	4,758	45	3,812	35	1,050	0								9,900	
46,000	9,200	66	6,022	56	4,922	46	3,992	36	1,080	0								10,150	
47,000	9,400	67	6,240	57	5,092	47	4,178	37	1,110	0								10,400	
48,000	9,600	68	6,462	58	5,268	48	4,368	38	1,140	0								10,650	
49,000	9,800	69	6,690	59	5,450	49	4,562	39	1,170	0								10,900	
50,000	10,000	70	7,000	60	6,000	50	5,000	40	1,200	0								11,150	

¹ Unit of expense = 20 percent of total income of family.

Note.—Credit for private plan benefits. The total amount of private plan benefits paid, reduced only by the amount of the annual deductible, is divided by "unit of Ex-

pense". The resulting whole number will fully offset an equal number of "Successive Units of Expense". Any remainder (fraction) will offset pro-rata the next "Successive Unit of Expense".

Exhibit IV

Public Medical Care - 1

	PEOPLE	TOTAL COSTS	SHARE OF COSTS		
			Federal	State	Local
1965	1.5 million	\$ 449 million	\$ 79 million	\$ 172 million	\$ 198 million
1966	2.0 million	\$ 532 million	\$ 217 million	\$ 171 million	\$ 144 million

Public Medical Care - 2

	ELIGIBILITY			MAXIMUM POTENTIALLY ELIGIBLE	POTENTIAL COST
	Income	Savings	Insurance or burial		
1963	\$ 5200 NET	\$ 1300 ($\frac{1}{4}$)	\$ 500	5.55 million people	\$ 797 million \$ 144 ⁰⁰ /capita
1963 updated	\$ 5700	\$ 1425 ($\frac{1}{4}$)	\$ 500	5.7 million	\$ 832 million \$ 145 ⁰⁰ /capita
1966	\$ 6000	\$ 3000 ($\frac{1}{2}$)	\$ 1000	8.0 million	\$ 1,032 million \$ 130 ⁰⁰ /capita

Public Medical Care-3**1965****1966**

FEDERAL AID-WELFARE MEDICAL \$221 MILLION		FEDERAL AID-WELFARE MEDICAL \$434 MILLION	
Medical-Aged	141	Medical	326
Old Age	15	Over 65 (State Hosp.)	61
Disabled	27	TB & Mental (Gen. Hosp.)	23
Blind	1	Phys. Handicapped Children	16
Dependent Children	37	Foster care Children	5
		Children-Home Relief	3
NON-FED. AID PUBLIC MEDICAL \$228 MILLION		NON-FED. AID PUBLIC MEDICAL \$98 MILLION	
Over 65 (State Hosp.)	61		
TB & Mental (Gen. Hosp.)	23		
Phys. Handicapped Children	16		
Foster Care Children	5		
Children-Home Relief	3		
Adults-Home Relief	10	Medical Care-Adults	11
Hospital-Only Care	110	Adults-Home Relief	16
		Hospital-Only Care	71

Program comparison

	1965 program	Federal law 19	New York law
Relative responsibility.	1. Spouse. 2. Parents for children. 3. Children for parents.	1. Spouse. 2. Parents for children under 21. 3. Parents for disabled and blind children over 21.	1. Spouse. 2. Parents for children under 21.
Benefits and services.	Comprehensive benefits available.	Include hospital, outpatient, laboratory, X-ray, nursing home and physicians services. (Comprehensive benefits by 1975.)	Comprehensive benefits available.
Coverage for adults 21 to 65.	Nonfederally reimbursed care furnished by State and local governments (\$228,000,000).	No reimbursement for those not related to Federal categories.	Nonfederally reimbursed care furnished by State and local governments (\$98,000,000).

CHART 3

Source	Rockefeller 1967 budget	Wyman	1966 budget	1966 cost, actual	1965 cost, actual
Federal Government.....	\$236,888,000	\$278,000,000	\$217,000,000	\$120,000,000	\$79,000,000
State government.....	210,560,000	250,000,000	171,000,000	115,000,000	172,000,000
Local government.....	210,560,000	210,000,000	144,000,000	115,000,000	198,000,000
Total.....	658,008,000	738,000,000	532,000,000	350,000,000	449,000,000

EXHIBIT V

MEDICAID AMENDMENTS

BACKGROUND

Prior to the preparation of proposed amendments to the current Medicaid program, consideration was given certain basic criteria. These criteria are:

1. For any program affecting a large portion of the population of the state, which has an appreciable affect on the medical and dental professions and the medical well being of the people, and which will directly affect taxes, firm control must be maintained by the state legislature.

2. The rules for the Medicaid program must be sufficiently clear as to be understandable by the people who are potentially eligible. These rules should be designed so as to effectively reduce the administrative portion of the costs of the plan.

3. The program should be designed so as to eliminate "negative incentives" for families desiring to improve their economic status.

4. The use of private or group insurance should be encouraged, although not made compulsory.

5. In determination of eligibility, the Medicaid program should not discriminate against the type of savings or investment assets a family or household possesses.

6. Eligibility for medical assistance should be determined on a calendar year basis, rather than a monthly basis.

7. The program should be so constructed as to minimize the possibilities of manipulation.

8. Certain household groups with limited income and resources may be unable to pay any portion of their medical expenses.

9. As income increases within a household of a given number of persons, their ability to pay medical expenses increases.

10. Where a household can afford to, it should pay all or a portion, above certain minimum levels, of each medical expense incurred.

11. Provision should be contained in the program to prevent families or households of some means from being reduced to the poverty level in the event of catastrophic medical expenses.

12. Above certain minimum levels, some portion of a family's or household's assets should be expended for medical hardships before they receive medical assistance.

The Medicaid amendments being prepared on the following pages are based upon these criteria.

EXHIBIT VI

[Reprinted, with permission from the Journal of the American Medical Association, Apr. 8, 1961]

THE COMING DIN OF INEQUITY

(By Ray M. Peterson, vice president and associate actuary, the Equitable Life Assurance Society of the United States)

A great national debate is now in progress as to the issue of providing medical care and hospital benefits under the social security system. That debate can be pursued intelligently and wisely only if we understand the true nature and implications of the social security financing mechanism. Advocates of the social security approach assert that it is best because the social security financing mechanism is "time-tested" and "tried and proved."¹ In my opinion this is not so. The social security financing mechanism has not yet met the test of time; its crucial tests still lie ahead. To argue otherwise either reveals an inaccurate or incomplete conception of the true nature of the social security financing mechanism or suggests a willful attempt to distort and misrepresent.

¹ Meany, G.: Report of President's Commission on National Goals, *Goals for Americans*, Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1960, p. 30; Rockefeller, N.: Governor's 1961 Message, *New York Times*, Jan. 5, 1961; Democratic Party Platform Committee, C. Bowles, Chairman: Text of Abbreviated Platform, *New York Times*, July 13, 1960.

One purpose of this paper is to set the record straight by portraying an accurate picture of the financing mechanism as now operating and by exposing the distortion and misrepresentation, no matter what its origin. Another purpose, and the main one, is to show that there are excellent reasons for grave concern as to the probable ultimate effects of continued distortion and misrepresentation by interpreters of the Social Security Act, by statements of inadequately informed members of Congress, and even by publications of the Social Security Administration itself.

Such concern arises because the public is being given the false impression that our social security program has many of the unique attributes of voluntary private insurance—attributes which the American people have come to value highly. When the American people ultimately come to know that the nature of our social security program is distinctly different, a rude awakening may well occur, one which could have important political and economic consequences. Will the youngsters of the future protest what the oldsters of this generation have voted for themselves? During the decade ahead, will we oldsters, as we seek to enjoy our social security benefits, hear a rising clamor of unfairness—a din of inequity? Let us examine the situation that is building up.

BACKGROUND INFORMATION

Here is some vital background information. In financing a national old-age pension program, there are possible two approaches as extremes—"pay-as-you-go" and full reserve—and an infinite number of combinations of the two.

"Pay-as-you-go" financing, as the term is used in the field of social insurance, means that the Government raises currently through taxes just enough funds to pay the cost of benefits currently due. No reserve is accumulated; no element of *prepayment* is involved; money is raised as and after payees become eligible to receive benefits. In this latter sense (i.e., relative to the time persons become eligible for benefits) "pay-as-you-go" is really a *postpaid system* of financing.

Full reserve financing, on the other hand, is a *prepaid system* of financing. All benefits are fully paid for or financed during the year *prior* to the time they are entered upon. Under full reserve financing, the dollar sum of all payments into the fund, together with the interest income earned from its investment, is sufficient to pay off all liabilities for guaranteed or promised benefits. No benefits are promised beyond what can be provided for—any given point in time—by payments into the fund, plus interest earned.

Full reserve financing in the field of private insurance is the test of *actuarial* soundness, and it is the only concept of actuarial soundness with which the American people are generally familiar. The actuarial soundness of private insurance is assured by the use of *insurance principles*; any fiscal soundness (not actuarial) possessed by social insurance depends mainly on the *taxing power* of the Government. To call a social insurance program actuarially sound just because income balances outgo is to misuse the term.

Two other important points need to be made. One is that under voluntary private insurance, the principle of *individual equity* is preserved; i.e., there is a direct relationship between contributions and benefits; one receives as insurance or annuity coverage precisely what one pays for. This is rarely the case under a social insurance program. There a new concept, called *social adequacy*, prevails. As defined by R. A. Hohaus,² in 1942: The measure of protection should be "social adequacy" for the insured and their families—that is, it should represent, as far as practicable, a basic layer of protection. "Social adequacy" usually makes it impractical to have "individual equity" for the insured in the sense of a mathematical *quid pro quo* return on account of the contributions made by or on behalf of the individual. A socially adequate benefits provides an income sufficient as basic protection against want and destitution, and, consequently, may be much more, or even much less, than an "equity" benefit.

TRUE NATURE OF SOCIAL SECURITY FINANCING

Now, let us establish the true nature of our social security financing mechanism. Envolving through a political process, there has been, beginning with the 1939 Amendments, a continuing shift away from substantial individual equity

² Hohaus, R. A.: Social Insurance In a Democracy, *Proceedings of American Life Convention*, Oct. 7, 1942, Chicago.

toward social adequacy, and the financing method has become a mixture of full reserve financing and "pay-as-you-go," with the latter far outweighing the former. All this has been clearly stated by the Chief Actuary of the Social Security Administration.³ With respect to the gradually emerging philosophy of benefits, the Chief Actuary said:

"The issues of underlying philosophy for an old-age benefit formula under the social insurance approach have been summed up in the expression 'individual equity versus social adequacy.' It was generally recognized that individual equity is of paramount importance in administering voluntary old-age insurance on a sound financial basis since each individual has the right to purchase insurance or not as he wishes. However, under a governmental social insurance plan, individual equity in the relationship of the individual's future benefit to his current contribution is not essential to financial soundness, since the individual has no choice as to being covered or as to his rate of benefits or contributions.

"The issue was resolved in the 1939 Amendments by a major change in emphasis, as a result of which the old-age benefit formula is based largely on the adequacy concept—and thus to only a small extent on the equity concept."

Then, as to the financing method, he added:

"The principles upon which to base the financing of old-age and related benefits in a social insurance system have been discussed at great length both in this country and abroad. . . .

"This debate was especially active early in the development of our old-age insurance system, when the size of the fund to be accumulated was a burning question. As is often the case in this country, the answer was arrived at through a pragmatic political process rather than through a theoretical philosophical process. And, as is also often the case, the pragmatic process has resulted in an answer which, to date at least, has worked out satisfactorily. Just as the benefit formula is a blend of equity and adequacy, with much greater emphasis on the latter, so is the financing method a blend of 'reserve' and 'pay-as-you-go,' with the latter having the greater weight. . . ."

Are these blends so bland as to blind us to blunders? There is grave danger of this.

Let us turn now to another authoritative source,⁴ which describes the "pay-as-you-go" nature of our financing method and shows that an individual's benefits are not financed by his own contributions but by the contributions of others. In an opinion handed down on June 20, 1960, the Supreme Court of the United States had this to say:

"The program is financed through a payroll tax levied on employees in covered employment, and on their employers. . . . The tax proceeds are paid into the Treasury 'as internal-revenue collections,' . . . and each year an amount equal to the proceeds is appropriated to a Trust Fund, from which benefits and the expenses of the program are paid. . . .

"Persons gainfully employed, and those who employ them, are taxed to permit the payment of benefits to the retired and disabled, and their dependents. Plainly the expectation is that many members of the present productive force will in turn become beneficiaries rather than supporters of the program. But each worker's benefits, though flowing from the contributions he made to the national economy while actively employed, are not dependent on the degree to which he was called upon to support the system by taxation."

In Great Britain, the national pension scheme was recently modified so as to bear considerable resemblance to ours both as to benefit formula and financing method. A recent British observer⁵ had this to say:

"The Conservative scheme is dignified with the actuarial name 'assessmentism' (the cost of the pensions is assessed annually and the contributions to pay them arranged accordingly), or in common parlance 'pay as you go'; the future pensioner is paying for existing pensions and will in turn have to trust to a future generation of taxpayers in his retirement.

³ Myers, R. J.: Methodology Involved in Developing Long-Range Cost Estimates for Old-Age, Survivors, and Disability Insurance System, *Actuarial Study No. 49*, U.S. Department of Health, Education, and Welfare, Social Security Administration, Division of the Actuary, May 1959.

⁴ *Flemming v. Nestor*, 363 U.S., p. 609 (1960).

⁵ Seldon, A.: Pensions for Prosperity, *Hobart Paper 4*, Institute of Economic Affairs, London, 1960.

"What is the employee's security in a state scheme? It accumulates no fund; the money he pays in goes out almost at once to pensioners; when he retires he will have to rely on the contributors and taxpayers, on the value of money, on the Government, on the economic and social climate, and on world conditions which the Government cannot control. If employees were told these things would there be an overwhelming vote for state pensions? For 'pay as you go' they might read 'hope as you pay.'"

For the years 1956 through 1965, tax collections for Old Age, Survivors, and Disability Insurance (OASDI) will total \$115.1 billion and OASDI benefits and expenses will total \$114.5 billion.⁶ These figures clearly show that we are now almost *completely* on a "pay-as-you-go" or "*hope as you pay*" basis.

A PERMANENT AND GROWING DEBT

Now, let us return to the terms "individual equity" and "social adequacy." What is their significance? Individual equity, remember, equates contributions (or taxes, employee's and employer's combined) and benefits; the benefit is earned by the contribution. A socially adequate benefit, however, may be more or less than an equity benefit. The fact is that, for the vast majority of *present* members of the OASDI system, benefits will be much greater than an "equity" benefit. An income that meets social needs includes a large element of unearned benefit or unearned increment for most of the *present* members. *But the pendulum swings the other way for the youngest members and for all new entrants.* Social adequacy for some means individual inequity for others.

The decided swing away from substantial individual equity toward social adequacy which began with the 1939 Amendments has been accelerated since 1939. This has been the result of *deferring* scheduled tax increases, *extending* coverage to new groups, and *increasing* benefits for both retired and nonretired groups without increasing the taxes with respect to them by an amount sufficient to cover the cost of their increased benefits.

One need not be an actuary to realize that if large classes of persons receive benefits of greater value than the taxes paid with respect to them, then somebody else must pick up the tab. The unearned benefits are in one sense a subsidy which the older generation has voted for itself, and in another sense a debt representing the present worth of the subsidy which that same generation has assigned to younger generations for service or payment. In view of Section 1104 of the Social Security Act giving Congress "the right to alter, amend, or repeal any provision" of the Act, this debt does not have the same legal character as the national debt represented by Government bond promises to pay, but if social security promises are to be honored, the debt is *just as real* as the national debt. The younger generations can either pay off the debt or they can settle for just paying the interest on it. Under the present system of self-support through payroll taxes, these are the only two choices seemingly open to them, short of congressional repeal.

But, is it that simple? Are there really two choices? The great emphasis on social adequacy has some very disturbing implications.

The first is the dawning realization that we have but one choice, and that choice is to pay the interest on the debt *forever*, since the debt is permanent! The only way the debt can be reduced is to have a given generation of workers build up a huge reserve fund (over and above present payments) solely for that purpose. To expect this to happen is to be politically and economically unrealistic. With no reserve fund in sight to reduce the debt, the burden being passed on to future generations is permanent. It is not something that will somehow work itself out, or go away; it is not an actuarial fantasy.

Second, not only is the debt permanent, but the burden being passed on to future generations is a *growing one*. Under the 1956 Act, the debt arising out of the unearned increments was estimated to be \$269 billion.⁷ This is the dif-

⁶ Myers, R. J.: Actuarial Cost Estimates and Summary of Provisions of Old-Age, Survivors, and Disability Insurance System as Modified by Social Security Amendments of 1960, prepared for use of Committee on Ways and Means, U.S. Government Printing Office, 1960.

⁷ Long-Range Cost Estimates for Old-Age, Survivors, and Disability Insurance under 1956 Amendments, *Actuarial Study No. 48*, U.S. Department of Health, Education, and Welfare, Social Security Administration, Division of the Actuary, Aug. 1958.

ference between (a) the present worth, \$486 billion, of all future benefits and expenses for all persons *then* OASI members and (b) the sum of the present worth, \$194 billion, of all future taxes with respect to such members and the trust fund, \$23 billion. The corresponding present worth of unearned increments at the end of 1958 was \$289 billion.⁸ Estimates of the writer, based on available data, show the debt growing from about \$150 billion under the 1952 Act to \$200 billion under the 1954 Act, and on to about \$300 billion under the 1958 Act. The 1960 Act will produce some further increase.

Third—and most serious of all—because of this debt, employee and employer taxes with respect to the average new entrant will always exceed the value of the benefits such a new member will receive. The constant combined employer-employee tax rate estimated as sufficient to pay for all future benefits was 7.00%⁹ of taxable payrolls under the 1954 Act. Of this, 4.60% was needed to support benefits for the average new entrant, and 2.40% was interest on a debt of about \$200 billion. Under the 1958 Act, such tax rate requirement was about 8.75%,⁹ of which 5.25% was needed for a new entrant and 3.50% for interest on a debt of about \$300 billion. Under the 1954 Act, the value of total new entrant taxes was 152% of the value of the benefits (7.00 divided by 4.60); under the 1958 Act this became 166% (8.75 divided by 5.25). There is no intrinsic reason why this percentage cannot exceed 200%. At this point, the average new employee, alone, more than pays his own way. Today, the average *new* self-employed person is paying 20% more than the value of his benefits. The taxes payable by and in respect of the new entrant must *forever* be greater in value than the value of the benefits that the new member will receive. *The price of social adequacy is perpetual individual inequity.*

When the magnitude of this individual inequity becomes more fully understood, will a "din of inequity" arise? Will there be a demand for support from general revenues? Will there be a refusal to pay increased social security taxes? Will there be a demand for reduction of benefits? Will an employer ask a private insurance company whether he can obtain larger benefits for new employees with the same joint employer-employee contributions? If he should ask me, this is what I would have to say. "About 80% of joint employee-employer taxes involving your new employees is for old-age benefits for the employee, his wife or widow. The remaining 20% is for survivor and disability benefits before retirement. Depending upon the marital status and the sex of your *new* employees and the rate of earnings, this 80% of taxes would buy under an Equitable group annuity contract, at our present rates, 40% to 60% more in old-age benefits than are provided under the OASI system."

The foregoing situation would be further aggravated if more is added to this unearned-increment debt by deferral of scheduled tax increases and by benefit increases without fully compensating tax increases with respect to those receiving the benefits. This is to be expected because the 1958 Advisory Council on Social Security Financing questioned whether the 1969 tax increase should go into effect, and benefits are almost certain to be increased by Congress.

TRUST FUND VS. VALUE OF CURRENT BENEFITS

The shift in principle from individual equity to social adequacy and from "full reserve" emphasis to "pay-as-you-go" financing is vividly reflected by the change in the relationship between the amount of the Old Age and Survivors Insurance (OASI) Trust Fund and the value of the benefits for persons currently on the benefit rolls (Disability Benefits and Trust Fund excluded). The following table shows, for example, that if taxes had ceased in 1950, the trust fund would have covered 113% of the benefits promised for the future for those then in receipt of payments; but if taxes should cease in 1965, it is estimated that *only 20% of the benefits for those then on the rolls would be covered, with no provision for those not on the rolls.*

⁸ ——— Actuarial Cost for Long-Range Social Insurance Benefits, *Proceedings of Conference of Actuaries in Public Practice*, Vol. IX, p. 337.

⁹ Peterson, R. M.: Misconceptions and Missing Perceptions of our Social Security System (Actuarial Anesthesia), *Transactions of the Society of Actuaries*, Volume XI, Nov., 1959, pp. 820, 898.

*Relation of trust fund to value of benefits in current payment status*¹

[In billions of dollars]

(1) Year	(2) Trust fund	(3) Value of benefits	(4) Ratio of (2) to (3) (percent)
1945-----	\$7.12	\$2.31	309
1950-----	13.72	12.10	113
1955-----	21.66	39.32	55
1960-----	20.15	88.28	23
1965-----	23.14	114.23	20

¹ Estimates based on (a) Annual Statistical Supplement, 1958, Social Security Bulletin; (b) "Present Values of OASI Benefits in Current Payment Status, 1940-1956," Actuarial Study No. 45, U.S. Department of Health, Education, and Welfare, Social Security Administration, Division of the Actuary; and (c) Reference 6.

In the 20th Annual Report¹⁰ of the Trustees of the OASDI funds, an estimate is made of the progress of the OASI Trust Fund "in the unlikely event of a sharp reduction in the level of economic activity during calendar years 1960-1964, with a relatively high rate of unemployment during the entire period." Based on these estimates, the OASI Trust Fund would drop to only 10% of the value of benefits current in 1964!

EXPANSION BEYOND SOCIAL ADEQUACY

We have observed the growth of unearned increments and the departure from individual equity in the name of social adequacy. For a social insurance system established to provide only a minimum basic coverage as protection against want and destitution, this is fully justified. It is in harmony with the 1937 Supreme Court decision which declared the system constitutional as a welfare measure. The advocates of great expansion of social programs, however, have now dropped the adjective "social" and speak only of adequacy. Here are proposals for departure from social adequacy to higher orders of "adequacy."

Professor Wilbur Cohen¹¹ of the University of Michigan (now Assistant Secretary of Health, Education, and Welfare) recently said we must develop a concept of "greater adequacy." Speaking of the 50-50 payroll tax financing, he said that there was no reason why it could not be 40-60, or have the government make a substantial contribution.

Nelson H. Cruikshank,¹² Director of the AFL-CIO Department of Social Security, recently wrote:

"The proportion of present earnings that is represented by benefits on retirement must be materially increased for workers in the middle and upper income brackets. A worker with average wages in industry today receives only about 30 percent of his present earnings. In order to keep pace with the rising levels of living and to maintain confidence of the system on the part of those in the middle and upper wage ranges, he should receive 25 years from now, or sooner, at least 60 percent of his earnings on retirement."

(Based on a current average wage of \$4600, the primary amount is about 32% for an employee, and the total benefit for a married couple is 48%.)

These proposals go far beyond the concept of social adequacy. Their enactment could increase the permanent social security debt to more than one-half trillion dollars.

TRUE NATURE OF SOCIAL SECURITY RIGHTS

The true nature of social security rights has been well stated by the Solicitor-General of the United States and by the Supreme Court of the United States.

¹⁰ 20th Annual Report of Board of Trustees of Federal Old-Age and Survivors Insurance Trust Fund and Federal Disability Insurance Trust Fund, U.S. Government Printing Office, 1960, p. 28.

¹¹ Cohen, W. J.: Frontiers in Social Security, highlights of remarks at dinner meeting May 7, 1959, sponsored by Washington Chapter of the Industrial Relations Research Association, unpublished.

¹² Cruikshank, N. H.: Social Security Challenge of Next 25 Years, *AFL-CIO American Federationist*, Aug. 1960.

Solicitor-General:¹³ "... social security must be viewed as a welfare instrument to which legal concepts of 'insurance,' 'property,' 'vested rights,' 'annuities,' etc., can be applied only at the risk of a serious distortion of language. We are dealing with a social instrument by which public action, involving compulsion, is invoked to deal with the social problem—the lack of basic economic security of large segments of our society. An understanding of the difficult and changing problems of public policy arising out of attempts to eliminate individual or family insecurity on a national scale will be obscured by Procrustean efforts to force the social security program into the mold of inappropriate analogies."

Supreme Court:¹⁴ "The Social Security system may be accurately described as a form of social insurance, enacted pursuant to Congress' power to 'spend money in aid of the "general welfare" ... It is apparent that the non-contractual interest of an employee covered by the Act cannot be soundly analogized to that of the holder of an annuity whose right to benefits are bottomed on his contractual premium payments.'"

INACCURATE PRIVATE INSURANCE PARALLELS

Space will permit only a few illustrations of statements which seek to liken social security to private insurance. (Emphasis has been added.)

I. Members of Congress

Congressman (now Senator) Keating:¹⁵ "it has always been my feeling that since *social security is essentially an insurance system*, there should be no limit on the amounts which beneficiaries can earn, and still receive benefits ... it is my feeling the ceiling should be removed entirely."

Senator Proxmire:¹⁶ "The fact is that *this is an insurance system*. This is a *premium* that he is paying. His employer is paying a part of the premium. It is entirely different from income tax. It is a benefit that comes back to him. *He is buying something for himself.*"

Senator Douglas:¹⁷ "I'm in favor of eliminating completely the limit on earnings of OASI recipients. To require all those getting OASI payments to give up gainful employment is, in reality, attaching a condition to *insurance which they themselves have bought.*"

Senator (now President) Kennedy¹⁸ (campaign statement): "I believe, with Governor Rockefeller, that people should be able to save for the medical care of their retirement years in the same way that they *set aside money* for other needs—*through the social security system*. My health plan would extend to our older citizens a *life policy of paid-up medical insurance*. It would afford them hospital benefits, nursing home benefits and x-rays and laboratory tests on an out-patient basis.

"It would allow people to provide for the costs of their retirement while they work—so that their needs could be met in later years without burdening their children."

It is evident from the earlier analysis in this paper that the social security financing mechanism *is not a savings system*, that the granting of unearned increments *creates a debt* that employees and employers of the future must cope with in perpetuity, and the Supreme Court opinion makes clear that there would be no such document as a "life policy of paid-up medical insurance."

II. Social Security Officials and Department Statements

Robert M. Ball,¹⁹ Deputy Director of the Bureau of OASI (in defense of the policy of fixing social security taxes without any initial income bracket exemp-

¹³ *Flemming v. Nestor*, 363 U.S. 603, *Appellant's Brief*, p. 68.

¹⁴ Ref. 4, pp. 609-610.

¹⁵ Keating, K. B.: Statement, *Hearings before Committee on Ways and Means, House of Representatives*, Eighty-Fifth Congress, second session on all titles of Social Security Act, U.S. Government Printing Office, 1958, p. 1075.

¹⁶ Proxmire, W.: Statement, *Hearings before Committee on Ways and Means, House of Representatives*, Eighty-Fifth Congress, second session on all titles of Social Security Act, U.S. Government Printing Office, 1958, p. 149.

¹⁷ Douglas, P. H.: Quoted in *The Christian Science Monitor*, Sept. 17, 1957, "The Reader Writes": "OASI Payments," letter from A. L. Dunn, New Orleans.

¹⁸ Kennedy, J. F.: YOU Asked Them: They've Answered: Medical Care for Aged, *Daily News* (New York), Nov. 4, 1960.

¹⁹ Ball, R. M.: Statement made by Deputy Director of Bureau of Old-Age and Survivors Insurance of Social Security Administration to Prof. R. M. Clark, quoted in *Economic Security for Aged in United States and Canada*, Report prepared for Government of Canada, 1959.

tion): "The argument as used in the United States for such a policy under Old-Age Insurance is that the contributions, though legally a tax, *are a premium* for social insurance benefits."

Charles M. Schottland²⁰ (formerly Social Security Commissioner): "Medical care for the aged can best be approached through the social insurance route. Nine out of ten persons reaching age 65 today are eligible for OASI benefits. They have *paid for these benefits* through a tax system which has been proved workable and financially sound."

Insurance For You and Your Family (1952):²¹ "Your account number on your social security card identifies your old-age and survivors insurance account. Your card is the symbol of *your insurance policy* under the Federal social security law."

Social Security Administration Release of November, 1959: "Beginning January 1, 1960, 50¢ more *social security tax* on every \$100 you earn (and 50¢ more from your employer) . . . *provide monthly payments for you and your family* at retirement, or when you are between age 50 and 65 and severely disabled."

III. Writers

Arthur Larson:²² "Social security is a combination of *old-age pensions, disability insurance, and life insurance*. The '*premium*' for this combination of benefits is a payroll tax of 5% on your wages up to \$4800 a year. . . .

"*Social security is based on the same principle as private insurance*, with variations to accomplish its social purpose and to keep it inexpensive.

"Social security differs in important ways from commercial annuities and private life and disability insurance, but the general idea is the same. The idea is that contributions are made by you (and on your behalf by your employer), in return for which you get certain insured rights, including pensions and death benefits."

Wilbur J. Cohen:²³ "*The proposal [social security financing mechanism] uses the tried and tested insurance method of payment for hospital and medical care with which millions of Americans of working age are familiar through Blue Cross and other private insurance.*"

Sidney Margolius²⁴ (referring to 1960 Amendments): "You and your family ought to know your Social Security benefits as thoroughly as you know how much money you have in the bank. *For that's what Social Security really is: money in the bank* against the day you might lose your income because of disablement, death of the family breadwinner or old age."

It must be clear to all discerning readers that, in the light of our initial analysis, there is no foundation for these inaccurate parallels. Indeed, there is desperate need to dispel these self-mesmerizing, foggy concepts.

SOCIAL SECURITY FINANCING OF MEDICAL CARE

What happens when the social security financing mechanism is used for medical care benefits? Let us first recall that the proponents of the contributory old-age and survivors insurance system, led by Arthur Altmeyer, have always been anxious to preserve the contributory principle; i.e., no one receives cash benefits under that system unless he contributes for a minimum period of time. Even though contributions have been only token payments for hundreds of thousands of members, Congress has adhered to this principle. Now, with an entirely new type of proposed benefits, i.e., medical care, for which the present persons on the old-age payment rolls would pay nothing, this principle is thrown overboard; all present social security payees would be blanketed-in. Also, millions of active workers and their employers would pay in taxes only a fraction of the cost of the benefits.

With no necessary application of the principle of social adequacy, another segment of unearned increment would be granted which would add to the permanent social security debt on which future generations and their employers would need to pay interest forever. A good guess would place this sum at \$25

²⁰ Schottland, C. M.: Medical Care Through Social Security: What Lies Ahead? *Public Welfare*, July, 1960.

²¹ *Insurance For You and Your Family*, Social Security Administration, 1952, p. 11.

²² Larson, A.: *Know Your Social Security*, rev. ed., New York: Harper & Brothers, 1959.

²³ Health and Social Security Task Force to President-Elect Kennedy; Cohen, W. J., Chairman, *Report*, Jan. 10, 1961, unpublished.

²⁴ Margolius, S.: New "Security" Rules Aid Young and Old, *Solidarity*, Oct. 28, 1960, p. 9.

to \$30 billion for the Forand bill, \$15 to \$20 billion for the Kennedy-Anderson bill, and around \$30 billion for the McNamara bill. This would be only the start. The admitted political technique is a fragmentary approach: separate pieces of benefits are added from time to time. The McNamara bill had two steps in benefits and a two-step progression of taxes. Furthermore, most students, pro and con, believe that it will be virtually impossible to limit benefits to the aged. Such benefits will inevitably be extended to all ages. In this steady procession of developments, the principle of social adequacy—the idea of basic protection against want and destitution—is lost, with no replacing anchor of control to restrain expansion of so-called social insurance.

CONCLUSIONS AND RECOMMENDATIONS

What to do? The objective of the social insurance system should be clearly enunciated. It is imperative that the objective be to serve only the limited purpose of social adequacy, the recognition of society's obligation to provide basic minimum protection against want and destitution. The objective should be unequivocally declared by the Congress. *As our society becomes more affluent, the relative role of social programs should diminish.* The following measures are necessary to meet that objective:

(1) *No further increases in OASDI benefits should be enacted except those required to recognize changes in living costs for the aged.* For this purpose, a special consumers' price index for the aged is needed and should be developed. Changes should be made only after careful consideration by Congress, and not automatically.

(2) Congress should enact legislation that will provide *tax incentives* for all persons to save for their own old age needs, including, in particular, funds dedicated to pay premiums for medical care insurance.

(3) *The self-supporting principle must be retained* so that we do not lose its values of cost control and cost-consciousness. If benefits are restricted to the social-adequacy level, pressure for support from general revenues can probably be successfully resisted.

(4) To promote better public understanding of the nature of the financing method and of social security rights, a separate agency, similar in function to the Federal Trade Commission and state insurance departments, should be responsible for checking all statements and publications of the Social Security Administration for the purpose of disclosing to the public inaccurate and incomplete statements.

(5) To promote better understanding of costs, congressional committees and other responsible persons not in Government should know, with respect to each proposed social security amendment under consideration, in addition to a single constant tax rate requirement: (a) the tax-rate requirement for the average new entrant; (b) the present worth of the unearned increments for present members; and (c) the tax-rate requirement for the interest on the additional debt represented by such increments.

The adoption of these measures may be expected to have the following salutary effects:

(1) As real wages increase, *lower rates* of social security taxes than those now in the law will suffice to support the present level of benefits, workers will have greater margins to save for their own old-age needs, and the wage-related feature of OASDI benefits will become less of a feature as more persons in the course of time will have the same flat benefit represented by the present maximum.

(2) As the American people gain a better understanding of the nature of the social security system with the social objectives limited as herein stated, and of the differences between private and social insurance, chances of *public acceptance of a certain measure of individual inequity* for coming generations would be much improved.

(3) As the following factors become effective it should become increasingly clear that provision of medical care benefits under the social security mechanism is unnecessary and unwise: (a) tax incentives to save for cash- and medical-care needs in old age; (b) the increasing capacity of present workers to save, as compared with the former capacity of the present aged; (c) the vigorous development of the Federal-State Medical Aid for Aged Program; and (d) the further evolution of voluntary private insurance.

Our social security system can be preserved only if we keep benefits within the limits of carefully defined social objectives. Abraham Epstein, a pioneer in the development of old age income programs, is reported to have said that social insurance is like a drug: a limited quantity can serve a vital need; an excessive quantity can be fatal.

If the recommended measures are not substantially adopted, but, instead, we attempt to finance cash benefits of "greater adequacy" and also full medical care benefits through the social security system on the self-supporting principle, and the system continues to be likened to private insurance, then surely a great Din of Inequity will be heard. The towering social security structure which we will have piously erected in the name of taking the burden of the old from the shoulders of the young will fall flat on our posterity!

The CHAIRMAN. Mr. Zahorsky, Mr. Brummit, Mr. Palombo. Mr. Zahorsky, if you will identify yourself and the others accompanying you for purposes of our record, we will be glad to recognize you, sir.

STATEMENT OF MICHAEL J. ZAHORSKY; ACCOMPANIED BY MORROS BRUMMIT, AND GUIDO PALOMBO; UNITED STEELWORKERS OF AMERICA DISTRICT 20 (PENNSYLVANIA)

Mr. ZAHORSKY. Chairman Mills, at a legislative conference held in Philadelphia on January 27-28, 1967, a resolution was unanimously adopted by the delegates who attended requesting the secretary of the legislative committee of Pennsylvania to check with the various pension committees of the United Steelworkers of America in Pennsylvania to see how the medical payments to our pensioners agreed with the fee schedule provided by medicare and also other unusual practices not provided for in the law.

As a result of this request, we are here today to give you our experience in regard to the medicare program as practiced in the Beaver Valley, Pa., area among the members of our union who have had occasion to use medicare.

Mr. Chairman and members of the Committee on Ways and Means, I am Michael J. Zahorsky, recording secretary of Local Union 1211, United Steelworkers of America, Aliquippa, Pa.

Together with my colleagues, Mr. Morros Brummit and Guido Palombo, president and financial secretary, respectively, and Mr. Charles Ford, executive secretary of the Pennsylvania Legislative Committee of the United Steelworkers of America, representing more than 300,000 steelworkers in the Commonwealth of Pennsylvania, we appear before you to give testimony in support of our president's proposal to revise or amend the medicare section of the social security system.

We are members of a local union of the great United Steelworkers of America, an organization of more than 12,000 members, a subordinate unit of the great Pennsylvania unit comprising more than 300,000 members and their families, and the international union with well over 1 million, just plain humble citizens interested in a happy family in a happy community in a strong and peaceful nation with helping hand to a needy human being, better may it be said, "We are our brother's keeper".

It is indeed gratifying to us, who as moles of the earth bring forth the ores and fuels and with the skills of our crafts, we witness our fruits rising into the heavens conquering space and time in the ulti-

mate reach for a better life in a better world to the benefit of all mankind.

For this privilege and opportunity we wish to thank you gracious committee. Be it therefore understood, we speak frankly and honestly that our few words will in a measure add to encourage better understanding to these problems we do wish to alleviate.

Our appearance before you today is to present for your consideration information that we have at hand and trust will assist you in recognizing the dire need of revising that section of the social security system which administers medicare.

Our testimony is gathered over the months since the inauguration of medicare July 1, 1966. We are not testifying under any persuasive or coercive indoctrination, but purely relating from our actual experiences in our everyday duties and services to our active and retired members of our union.

It is not our intention to embarrass or bring censure upon any citizen or groups of citizens, professional or otherwise, who may be encompassed or associated in those areas presented herein.

It is our sole intent and purpose to treat all subject matter as it has been received and given us, that from our testimony enlightenment may lead the way to a satisfactory revision of those unforeseen hardships in the medicare program as in effect today.

In essence it is our aim and purpose to testify in support of the President of the United States in making the revisions in the medicare section of the social security system which he believes necessary for the better well-being of the more than 20 million senior citizens of our country.

MEDICARE AND LABOR

With due respect to the National Council of Senior Citizens, Inc., no group in the United States has been as instrumental in the enactment of that section of the Social Security Act, medicare, as the united forces of organized labor, and with pride and special mention, the United Steelworkers of America.

With the goal in mind to help all our aged citizens, we had given our moneys and our time and efforts till we had attained the end so long sought. It was the most humane act passed by our Congress since the enactment of the Social Security Act of more than 30 years ago.

It is a great stride forward in assisting our aged citizenry to peace and comfort against the dreaded thought of hardships through illness in those last few years of life.

Labor supported medicare and exhibit No. 1 is one of several paid advertisements, paid for by our locals in support of medicare. Labor campaigned on the local, State, and National level for the support and ultimate enactment of the measure.

We do believe as we did then that only through such measure will our millions of aged citizens be more benefited than even by a few more dollars in their monthly old age benefits.

We have witnessed the joy of many of our retired steelworkers who compliment this great act of charity toward them.

Definitely we are satisfied with this great addition to our social security system and we are happy to pay the necessary moneys for continuation and improvement of medicare.

MEDICARE AFTER 8 MONTHS

Now that we have had the opportunity to live with medicare for 8 full months, how do we evaluate its effectiveness? As recording secretary of our local union 1211 it is among my duties to serve our retirees and guide them in matters of concern to them, to assist them with their problems.

Ours is a very large local union, in fact the largest local in the State of Pennsylvania and among the top five in the entire Nation. It is only normal that we should have a great number of retirees from so great a membership.

This in turn reflects in multiple problems in every area of concern to our pensioners. Previous to the inauguration of medicare we assisted them with their medical problems as provided for under terms of our negotiated contracts, in our case the nonprofit insurer or carrier Blue Cross and Blue Shield, since medicare a coinsurer.

In operation, the program had its shortcomings but we had adjusted to its limitation. In our area, as in most areas among our steelworkers, it is today the administrator of medicare, and a supplemental health insurance to medicare.

It was shortly after July 1, 1966, that we began to observe and learn of inadequacies in medicare, even so as to cause us to view with suspicion the easing of opposition to the enactment of medicare by the profession so vitally opposed previously.

One cannot be held responsible for what may come to his mind, but should at least make an attempt to learn the reason for such thought or opinion. We trust our frank testimony will in some measure remove this distasteful thought.

DOCTORS REQUIRE FULL PAYMENT FOR SERVICES

In every well-regulated society or business certain codes of ethics or regulations are necessary for the eventual success thereof, be it commercial, professional, governmental, or what have you.

However, here is where we have run into our first disappointment or disillusionment with medicare. Retirees came into our offices loaded with medical bills, doctors' requests for full payments for treatments and services rendered.

Many came in tears; many wives accompanied the emotionally disturbed pensioner; many called; many sought our advice and guidance.

What has happened to medicare?

Why do I have to pay all the doctor bills whereas heretofore all I was required to do was to sign my name and nothing more?

What have you led us to believe? Where is the greatest benefit told us previously?

Yes; it was confusion, misunderstanding, and utter disappointment.

Here is positive proof: medicare is somewhat less than we had bargained for.

Probably there is a solution and in time we will have ironed out the wrinkles of the program.

As we stated, previously to medicare the carrier or coinsurer covered many of what we feel are shortcomings with medicare and in this area where the doctor is requesting full payment or bill the patient direct an immediate revision must be made.

Our oldsters are requested to make full payments of the bills before the doctor will furnish them with a "Request for Payment" form, in itself a cumbersome and confusing bit of paperwork for any aged person.

In such cases the oldster having accumulated receipts for periodic and final payment to the doctor he was given the "Request for Payment" form.

Now, place yourselves in such a dilemma: How many oldsters are familiar with filling out their usual necessary applications for income taxes if they pay such, or even an automobile driver's license application, much less this form (exhibit No. 2)?

Why with only receipts for payments made, how in the world can you fill out the required questions as to nature of service, diagnosis, et cetera? Only an attending physician could do that, but have the patient return to the doctor for such completion of papers and you run into trouble or an extra fee.

In a great many cases bills were given to the collection agencies after a delinquency of, say, a month or two. But what of the delay our oldsters suffer until they are refunded the money. What collection weapon can they use?

In this area with assignment accepted by the doctor such fumbling and confusion can be eliminated. Herewith are exhibits Nos. 3, 4, 5, 6, 7, 8, 9, and 10; also a "Request for Payment" form—Exhibit No. 11, which was filled out by a truly dedicated and humane physician.

In these cases it is observed that doctors have requested full payment before they will furnish the forms. Now, will any of you honorable men tell me where that old retiree can scrape up \$200, \$300, \$400 or \$500 in hurry?

Give a thought to one of your parents receiving such a request if they be in the circumstances that the majority of aged citizens find themselves. Yes; and in cases I have been told they have been prompted to ask their children to assist them, to go to the bank and take out some of the savings they should have, or even to go to a loan shark who will gladly lend them the money.

Yes; and all the medicine and doctors in the world cannot administer a cure for the emotion that the oldster suffers in the meantime. We are asking you to please remove this stigma of being billed direct by the doctor, and we do believe you will.

It is just too bad that too many of our old folk are so sentimental that they are actually going into life savings to pay when medicare had promised them something better than they previously had.

Now that we have enlightened you on the direct billing by the doctors, does the disappointment end there? Will they eventually receive refunds as they had expected? Let us take a hard look at a case.

The patient had paid the doctor the full request payment; he had forwarded his request for payment together with his receipted statements to the medicare administrator. Several weeks or even months later he receives from medicare 80 percent of what is the prevailing fee for such a service in the specific area, according to the administrator, a specified directive.

In many instances many dollars short of what had been paid the doctor, even understanding that only 80 percent is reimbursed after the first \$50.00.

Yes; here again since medicare, agreed-to fees have been ignored, and where previously payment in full was made in the case, now probably a little more than 50 percent of the fee is paid. Medicare has in many cases removed the ceiling for certain services rendered; why?

Yes; it is just that everyone be compensated for the service he renders to society, but why must one assumed to be dedicated to alleviate human suffering, place dollars before service? I have not yet seen any medical man, and with due respect to most doctors, in any soup line, but I certainly have heard them cry for their money.

As early as a year ago retirees had come into our office informing us that notices were appearing in their doctor's offices to the effect that office calls would be increased in cases to as much as 50 percent, which from the minimum of \$5 would increase to \$7.50, and so forth.

In the cases of major surgery, there, too, the fees have taken a substantial jump, probably justified in cases but an exception should be made to those enrolled under medicare.

Under the sole hospitalization program of Blue Cross and Blue Shield these same people were given consideration under the "Paid in Full Benefits" incorporated in the program. Under that section of the agreement those who had limited incomes (and a very great majority of our senior citizens qualified) were afforded major medical and surgery at no added costs to them, the doctor, being a participating doctor under the Blue Cross-Blue Shield program, accepted the fee payment in full as negotiated.

Since medicare has been in effect, such "paid-in-full" benefits have disappeared from the practice, and the patient cannot point to the paid-in-full benefits for relief. In reply to a frequently asked question, "If I had spoken to any doctor in regard to fees after medicare?" I must say yes.

One doctor, a very prominent and very fine physician even called me after one of our retired steelworkers returned to his office regarding the fee and the completion of the request for payment form. His statement to me was that he cannot become an agent for the Government or a clerk for medicare; that he is too busy and the very little time he has to himself could be very easily taken up by this extra work.

Replying to my remark that his secretary could fill out such forms and could sign or even stamp his signature thereon, his reply was that he would need to engage another girl. Yes, but he failed to divulge that he would probably net at least \$10,000 more annually through increased fees which many doctors will blame medicare for.

I did have several anonymous calls to my office, one from a doctor's nurse or secretary, who told me how wonderful her doctor was and that I should not speak against him or any doctor as I did on the radio last night. (See exhibit No. 12.)

Gentlemen, we do not wish to criticize the medical profession, far from such. We do believe that nearly all doctors are men of dedication and honor and are deserving of our compliment rather than censure.

However, those distasteful and sporadic instances of one's explosion cannot be overlooked, but it would certainly be better if control or regulation would guide the questionable. Far from it be that it be said that we are facing absolute control of our medical professions, and the ills that both the patient and physician incur thereby.

We are aware of such sad experience in those places where such exists. We men of steel, men of organized labor, respect all organized people, even to the extent that our very Nation exists because of such institution.

PROPOSED AMENDMENTS AND/OR REVISIONS

In conclusion, we have become aware of a number of amendments and revisions which we unanimously endorse and request your honorable committee to consider.

These revisions we do believe will give and afford the added benefits that are so direly needed by our aged citizens. They encompass what we believe will make life a little sweeter for those who have contributed so generously to the fulfillment to make ours a greater society today.

(1) Eliminate all deductible and coinsurance features, waiting periods and enrollment deadlines.

(2) Lower the 65-year age limit for women to age 62.

(3) Pay medical specialist fees customarily provided by hospitals under part A of the medicare program.

(4) Establish fixed physician's fees under medicare so that no charges beyond these fees would be permitted.

In effect this would provide coverage for medicare beneficiaries similar to the service benefits available under many Blue Shield plans.

(5) Extend drug coverage to all prescription drugs for old people whether or not associated with hospital confinement.

(6) Extend coverage to include wheelchairs, eyeglasses, hearing aids, all surgical and orthopedic appliances and all eye and dental needs.

(7) Provide a planned program of multiphasic screening for preventive care before illness sets in.

(8) Permit persons eligible for medicare to go to the nearest Canadian hospital if they are stricken by illness or accident while across the border in Canada.

(9) Permit elderly people to be referred directly to nursing homes from hospital outpatient clinics instead of requiring hospitalization prior to admission to an extended care facility.

Closing, may we again express to you, Mr. Mills and the committee, our sincerest and most cordial thank you for hearing us. May divine providence guide you and our great President in these days of trials and tribulations and misunderstanding. May we always pray * * * when there is charity in the heart, there is harmony in the home * * * when there is harmony in the home, there is unity in the Nation * * * when there is unity in the Nation * * * there will be peace in the world.

Thank you.

The CHAIRMAN. We thank you, Mr. Zahorsky and those accompanying you, for this presentation of your views. We appreciate very much your coming to the committee.

Mr. ZAHORSKY. Mr. Chairman, I would want to add that we are missing several of the exhibits and the reason for that was that in the process of making up this testimony the machine had malfunctioned and we were unable to, but of the exhibits mentioned, copies of the ones that are missing in our testimony will be forwarded to you and the committee.

The CHAIRMAN. Without objection then they will all be included in the record.

(The attachments follow :)

EXHIBIT I

[From the Beaver County Times, Mar. 14, 1966]

LOCAL UNION 1211, UNITED STEELWORKERS OF AMERICA ENDORSES MEDICARE, THE FEDERAL GOVERNMENT HEALTH PLAN FOR THOSE AGE 65 OR OVER

If you have reached age 65 on or before December 31, 1965, you must enroll before March 31, 1966.

Benefits will be effective beginning July 1, 1966.

Those who are qualified to enroll now but fail or neglect to do so will not be given an opportunity to enroll again until October 1, 1967, and will become eligible for benefits July 1, 1968; and an increase of 10% in the rate will be effective.

If you reach your 65th after December 31, 1965, you have a 7 month period in which to enroll, 3 months before the month in which you reach age 65, and 3 months after the month.

If you reach age 65 before June 30, 1966, and enroll on or before that date, you will be eligible for benefits beginning July 1, 1966.

If you reach age 65 after July 1, 1966, and enroll in the month you are 65, you will be eligible for benefits the month following. For every month you enroll later than the month in which you become 65, you are penalized one month of eligibility. Those who are age 65 or over and are still working are subject to the same regulations as one retired.

It is advisable for everyone to continue their present Hospitalization (Blue Cross—Blue Shield) in order to be availed benefits not covered by Medicare. It is quite certain there will not be duplication of benefits. Information now available assures present retirees their wives who are not yet 65 will be covered as at present. In such cases, the premium will be reduced.

It is quite certain Hospital and Medical Services will be extended to those over age 65 and at less cost even with the \$3.00 per month which will be deducted from the monthly check of recipients of Social Security Old Age Benefits, or paid direct.

Your local Union 1211 advises you to enroll for Medicare now.

EXHIBIT 1-A

[From the Pittsburgh Post Gazette, Nov. 19, 1966]

OLDSTERS FIND DISADVANTAGES IN MEDICARE

(By Henry W. Pierce, Post Gazette Staff Writer)

Not all medicare patients are happy with the setup. Take James Lenhart, 72, of 1227 Denisonview St., Westwood. Last summer Mr. Lenhart had an acute gall bladder attack with peritonitis. He was hospitalized and operated on.

Came the surgeon's bill. Also bills from two other physicians and an ambulance driver. These the Lenharts sent in for payment through medicare.

Last week the Lenharts got their application back from medicare, along with a note telling them to pay the bills themselves, then send the receipts in for reimbursement through medicare.

"We have no money!" Mrs. Lenhart told this reporter. Her husband lost 10 weeks' work due to his illness. They had spent their last few dollars for the essentials of life and for the \$50 deductible all medicare patients must pay.

"In the 48 years we have been married we never received a bill that says 'please remit,'" she declared. "We always pay on the dot."

Mrs. Lenhart's position is not highly unusual, according to the Social Security Administration. Many elderly patients are starting to feel they were better off under the old system, in which Blue Cross would have covered their hospital bills and Blue Shield the surgeon's bill, and that would be that. (They forgot, of course, that neither Blue Cross or Blue Shield would have covered doctor's house calls, ambulance expenses, and other items medicare takes care of.)

The doctors themselves have the solution to this. They can take their patients' bills "on assignment," sending them in to medicare themselves. Many doctors in Western Pennsylvania are doing this.

But other physicians are not. For one thing, it means extra red tape and bookkeeping—which doctors generally abhor.

But there's more to it than that. Many doctors feel that, as one physician put it, "The public asked for medicare, and now the public's got it. Let them live with it."

The doctors fought medicare for years. The law was passed over the anguished tears and dire warnings of the American Medical Association. It's easy to see, then, how some doctors are going to feel about taking bills "on assignment." The public has its medicare now, so let the public fuss with its own bookwork. If a patient can't scrape up enough cash to cover the bills until medicare can repay him—well, that's what he asked for, isn't it? That's what the people wanted—let them get out of the stew themselves.

The doctors who do this are simply inviting more federal involvement. Soon we will be hearing proposals to make things easier for America's James Lenharts. Politicians will be submitting bills to "eliminate the inequities" in medicare. Dissatisfied medicare recipients will find this attractive.

Millions of other thoughtful Americans will sympathize with them. They will vote for those politicians. Then the one thing the doctors fear most will happen—medicare will be extended.

The doctors have it in their power to forestall this. To some extent, they can "take the inequities out of medicare" themselves. They can scotch the arguments that are, no doubt, already brewing in the minds of welfare advocates.

Taking bills on assignment would greatly simplify life for many medicare recipients; this one act could change the Lenharts from dissatisfied medicare patients to satisfied ones.

Some doctors are doing this. But if even a minority fail to do so, the way will be opened for the extended medicare they dread, and the old battle between the government and the AMA will start anew.

The AMA spends hundreds of thousands of dollars annually bemoaning what it believes is a trend toward full nationalization of medicine. Typically, the AMA fights every new proposal for non-voluntary government-backed systems of paying medical bills, only to present a counter-proposal itself at the last minute. Their counter-proposals usually have many good points, but they're presented after the measures the doctors have been fighting are all but passed.

The AMA could do more for its cause by seizing the initiative and presenting voluntary programs before the others get a foothold. The plight of the nation's

James Lenharts opens the way for constructive AMA action—if they have the daring, the initiative, and the imagination to do so.

BACK TO HIPPOCRATES

The Doctors, by Martin L. Gross (N.Y. 10022, Random House, \$6.95).

A librarian who told me of this book before I began reading it said that "it would make you never trust a doctor again." My reaction is different. In its 570 pages it exposes many of the weaknesses of the medical profession, but it has the crowning respect for the medical professional that is expressed by the desire to improve it.

The most reassuring thing about Martin Gross is his loyalty to an absolute moral code, an attitude especially to be found in his chapter on medical experimentation. There he unequivocally says that the physician may not experiment on anyone without his consent, which means that he can never experiment on babies, for whom even their parents cannot give proper consent, or even on his patients, who are in no position to give fully deliberate consent. He reaffirms the Geneva Code, which says: "I will maintain the utmost respect for human life from the time of its inception."

In fact, Gross's whole criticism of modern medicine is that doctors have wandered too far from the ethical and humane ideal of Hippocrates. He insists that they must be educated in the humanities as well as in their science. He pleads for a return of the doctor-patient relationship as exemplified in earlier practice.

Although criticism fills every page, this is not a debunking book. Gross lacks the facile irony of Jessica Mitford, who blasted the undertaking profession three years ago. He exhibits an intimate knowledge of medical problems and makes constructive suggestions to meet them. Here are some of them:

Establish a National Academy of Medicine to orient medical training, practice, and investigation. Set up higher philosophical goals, calling for doctors more analogous to the clergy.

Devote more time at medical college to clinical education—the diagnosis and treatment of patients.

Pursuant to a de-emphasis on money-making and social rating, regulate doctors' hours so that some doctors will always be on hand. Abolish the doctorless weekend.

Establish a free tuition program for all promising medical students.

No doubt many doctors will question some of Gross' charges, for example that some 100,000 patients die each year from diseases caused in the course of treatment, or the extent of needless death through neglect and ignorance in the hospitals.

But this is a constructive and readable book, a helpful layman's guide to medicine in our age.—Paul H. Hallett.

[From the Pittsburgh Press, Dec. 5, 1966]

DOCTORS TOLD: SIGN FORMS FOR MEDICARE

WASHINGTON, Dec. 5 (UPI)—The nation's physicians were put on notice today that they must sign the detailed Medicare hospital forms whether they like it or not.

The government doesn't plan to budge in its position.

Specifically, the Social Security Administration, which administers Medicare, commented on instances at hospital in Lancaster and Mount Vernon, Ohio, where several doctors have refused to sign so-called "certification" forms.

As a result, the Lancaster-Fairfield Hospital has been refused about \$60,000 in federal medicare payments because of the physicians' stand.

The administration added that as soon as the doctors in Lancaster sign the required forms, the hospital will receive the funds due. The only other instance similar to the Ohio situation was reported at Muncie, Ind., several months ago, but it has been resolved.



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

REQUEST FOR PAYMENT
MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT
(Type or Print all information)

Form Approved
Budget Bureau No. 72-R7311

MEDICARE
PENNSYLVANIA BLUE SHIELD
Box 65
Camp Hill, Pa. 17011

Copy from
your HEALTH
INSURANCE
CARD

NAME OF BENEFICIARY (Patient)

CLAIM NUMBER

☐ MALE ☐ FEMALE

PART I—CLAIMS INFORMATION—TO BE COMPLETED BY PATIENT.

1. Describe the illness or injury for which you received treatment. (You do not need to complete this item if your doctor completes Part II below)

EXHIBIT #2

2. Was your illness or injury connected with your employment? ☐ YES ☐ NO

3. Are you attaching itemized receipted bills? ☐ YES ☐ NO

4. ASSIGNMENT: Do you want payment for an unpaid bill made directly to the physician or supplier? ☐ YES ☐ NO
AUTHORIZATION: I authorize release of any information required to act on this claim and permit a photographic or other facsimile reproduction of this authorization to be used in place of the original.
REQUEST FOR PAYMENT: I am requesting payment either to myself or to the party accepting my assignment for the medical insurance benefit, if any, payable for the reasonable charges for services or supplies described. Where payment is assigned, I understand I am responsible for the deductible and 20% of the remaining reasonable charges.

5. SIGNATURE (Patient or authorized representative)

DATE SIGNED

6. ADDRESS (Street address, City, State, ZIP Code)

TELEPHONE NUMBER

PART II—REPORT OF SERVICES—TO BE COMPLETED BY PHYSICIAN—

This Part, Including Physician's Signature, Need Not Be Completed If Paid, Itemized Bills Are Submitted.

A. DATE OF EACH SERVICE	B. PLACE OF SERVICE ¹	C. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	D. NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES (Diagnosis)	E. CHARGES	Leave Blank
				\$	

8. NAME AND ADDRESS OF PHYSICIAN OR SUPPLIER (Number and street, City, State, ZIP Code)

TELEPHONE NUMBER

9. Total Charges \$

CODE NO.

10. Amount Paid \$

11. Any Unpaid Balance Due \$

12. ASSIGNMENT OF PATIENT'S BILL
(See reverse)

☐ I ACCEPT ASSIGNMENT

☐ I DO NOT ACCEPT ASSIGNMENT

13. SIGNATURE OF PHYSICIAN OR SUPPLIER (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)

☐ MD ☐ DO ☐ DDS OR DMD

DATE SIGNED

¹O—Doctor's Office

IH—Inpatient Hospital

ECF—Extended Care Facility

OL—Other Locations (Specify in 7C)

IL—Independent Laboratory (give name and address in 7C)

H—Patient's Home

OH—Outpatient Hospital

NH—Nursing Home



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
00865

REQUEST FOR PAYMENT
MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT
(Type or Print all Information)

Form Approved.
Budget Bureau No. 72-R730

MEDICARE
PENNSYLVANIA BLUE SHIELD
BOX 65, CAMP HILL, PA. 17011

Copy from
your HEALTH
INSURANCE
CARD

NAME OF BENEFICIARY (Patient)

*

CLAIM NUMBER

168-10-1906

☒ MALE ☐ FEMALE

PART I—CLAIMS INFORMATION—TO BE COMPLETED BY PATIENT.

1. Describe the illness or injury for which you received treatment. (You do not need to complete this item if your doctor completes Part II below)

EXHIBIT 3

2. Was your illness or injury connected with your employment?

☐ YES ☒ NO

3. Are you attaching itemized receipted bills?

☐ YES ☒ NO

4. ASSIGNMENT: Do you want payment for an unpaid bill made directly to the physician or supplier?

☒ YES ☐ NO

AUTHORIZATION: I authorize release of any information required to act on this claim and permit a photographic or other facsimile reproduction of this authorization to be used in place of the original.

REQUEST FOR PAYMENT: I am requesting payment either to myself or to the party accepting my assignment for the medical insurance benefit, if any, payable for the reasonable charges for services or supplies described. Where payment is assigned, I understand I am responsible for the deductible and 20% of the remaining reasonable charges.

5. SIGNATURE (Patient or authorized representative)

DATE SIGNED

6. ADDRESS (Street address, City, State, ZIP Code)

* Ave. Aliquippa, Pa.

TELEPHONE NUMBER

375-7829

PART II—REPORT OF SERVICES—TO BE COMPLETED BY PHYSICIAN—

This Part, Including Physician's Signature, Need Not Be Completed If Paid, Itemized Bills Are Submitted.

A. DATE OF EACH SERVICE	B. PLACE OF SERVICE	C. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	D. NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES (Diagnosis)	E. CHARGES	Leave Blank
11-19-66 thru 12-31-66	I H	Cholecystectomy B12, digitalis	acute gangrenous gall. bladder muscular fibulation (terminous stenosis)	\$ 138.00	

8. NAME AND ADDRESS OF PHYSICIAN OR SUPPLIER (Number and street, City, State, ZIP Code)

E E TREIDEL MD
698 MAPLEWOOD AVE
AMBRIDGE PA

TREIEE698

TELEPHONE NUMBER
266-4509

CODE NO.
02560

9. Total Charges \$ 138.00

10. Amount Paid \$

11. Any Unpaid Balance Due \$

12. ASSIGNMENT OF PATIENT'S BILL

☒ I ACCEPT ASSIGNMENT

☐ I DO NOT ACCEPT ASSIGNMENT

13. SIGNATURE OF PHYSICIAN OR SUPPLIER (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)

E E Treidel

☒ MD ☐ DO ☐ DDS OR DMD

DATE SIGNED

3-2-67

1O—Doctor's Office

IH—Inpatient Hospital

ECF—Extended Care Facility

OL—Other Locations (Specify in 7C)

1L—Independent Laboratory (give name and address in 7C)

H—Patient's Home

OH—Outpatient Hospital

NH—Nursing Home

FORM SSA-1490 (4-66)

*Blanked out by Ways and Means Committee.

DR. CHAS. H. WOLFE

Reg. No. 7368

Phone: 266-2390

DR. ERNEST E. TREIDEL

Reg. No. 5101

Phone: 266-4509

Office Hours: 1 to 3 & 7 to 9 P. M. Sunday By Appointment

Cor. Maplewood Ave. and Seventh St.

Ambridge, Pa. 15003

FOR.....AGE.....

ADDRESS.....DATE.....

R. Mr. *

This bill will be covered
by medicare. Please sign
your name on No. 5
and mail it to medicare.

E. E. Treidel

M. D.

REPETATUR YES ☐ NO ☐ TIMES.....I.D.

*Blanked out by Ways and Means Committee.

FORM SSA-1533 (8-66)



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

NOTICE OF HOSPITAL INSURANCE UTILIZATION

NAME AND ADDRESS OF THE BENEFICIARY
OR REPRESENTATIVE OF THE BENEFICIARY

ALQUIPPA PA

15001

DATE: 2-24-67

HEALTH INSURANCE CLAIM NUMBER:
168-10-1906A

The bill for HOSPITAL INSURANCE services described below was recently submitted under your health insurance claim number and recorded to your account.

TYPE OF SERVICES	DATES COVERED BY BILL		NUMBER OF HOME HEALTH VISITS INCLUDED
	FROM	TO	
INPATIENT HOSPITAL	11-19-66	12-31-66	

Institution or agency providing services } SEWICKLEY VALLEY HOSP
BLACKBURN RD
SEWICKLEY PENNSYLVANIA 15143
Office which handled your claim } BLUE CROSS OF WESTERN PENNSYLVANIA
1 SMITHFIELD STREET
PITTSBURGH PENNSYLVANIA 15222

For each spell of illness, your HOSPITAL INSURANCE under Medicare pays the costs of all covered services, with certain exceptions. These are the exceptions for this bill:
\$40.00 FOR THE FIRST \$40 OF INPATIENT HOSPITAL SERVICES.

THIS IS NOT A BILL.

RECORD OF ADDITIONAL BENEFITS AVAILABLE

As of the date of this notice, your record of inpatient hospital and extended care benefits for the spell of illness involved and your record of home health benefits is as follows:

INPATIENT HOSPITAL DAYS			EXTENDED CARE FACILITY DAYS			HOME HEALTH VISITS		
USED THIS BILL	USED TO DATE	REMAINING	USED THIS BILL	USED TO DATE	REMAINING	USED THIS BILL	USED TO DATE	REMAINING
42	42	48	NONE	NONE		NONE	NONE	

A NEW SPELL OF ILLNESS CAN BEGIN ONLY AFTER YOU HAVE NOT BEEN AN INPATIENT IN ANY HOSPITAL OR EXTENDED CARE FACILITY FOR 60 CONSECUTIVE DAYS.

If you have to use HOSPITAL INSURANCE services again, please take this latest notice with you and show it, along with your Health Insurance card, to the agency or institution furnishing the services.

Robert M. Ball
Robert M. Ball
Commissioner of Social Security

*Blanked out by Ways and Means Committee.

PLEASE READ THE OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION.

STATEMENT

JOHN S. LIGGETT, M. D.
JOSEPH B. GRIFFITH, M. D.
J. HOWARD CLARK, M. D.
337 BEAVER STREET
SEWICKLEY, PENNSYLVANIA

TELEPHONE 741-7880

March 19 67

*

Aliquippa, Pennsylvania

FOR PROFESSIONAL SERVICES

\$ 280.00

280.00 SEWICKLEY, PENNSYLVANIA 3/3/67

RECEIVED FROM M. I.

Two Hundred Eighty DOLLARS

FOR PROFESSIONAL SERVICES

AMOUNT OF ACCOUNT \$ 280.00

AMOUNT PAID \$ 280.00

BALANCE \$

JOHN S. LIGGETT, M. D.
JOSEPH B. GRIFFITH, M. D.

Paid in full

BY: aew

ALIQUIPPA, PA.

ESSEX 5-1022

2315 MILL ST.

DAVID C. BENNIGHOF, M. D.

3/1/67

192⁰⁰

FOR PROFESSIONAL SERVICES

STATEMENT

*

Aliquippa, Pa. 3/3/67

Mr.

RECEIVED OF

Three Hundred and Twenty Five

DOLLARS

*

Paid in full

\$ 325.00

I give this Office all today 4-5-67
Robert Cantabene, M.D. for

* Blanked out by Ways and Means Committee.

TRANSIT NO.	CHECK	AMOUNT	REC'D BY	DATE	RECEIPT NO.	PATIENT NAME	PATIENT NUMBER	IN-PATIENT ACCTS. REC.	OUT-PATIENT	OTHER
				12-21-66	88830		130752			
JNT RECEIVED						ACCOUNT CREDITED				

RECEIPT OF THE ABOVE PAYMENT IS GRATEFULLY ACKNOWLEDGED

SEWICKLEY VALLEY HOSPITAL
SEWICKLEY, PA.

Nº 83830

TAIL OF CHECK PAYMENT	
IT OF CHECK	
XCHANGE	
MT. RECEIVED	

PAID BY _____ (PERSON OTHER THAN PATIENT)

NAME		AGE	PATIENT NO.	579094
ADDRESS		BLUE CROSS NO. OR INSURANCE NO.		
		EMPLOYER		
		EMPLOYER'S ADDRESS		

MEMO.	DATE	DESCRIPTION OF SERVICE	AMT. CHARGED	AMT. CREDITED	BALANCE DUE	PICKUP	REGISTER NO. OR CLASS NO.
V.N.A. - 3 (4x3) to	JAN-3-67	REMOVED	0.75		0.75		A 2-23
per sponges & 1	2						
roll 1" adhesive	3						
.75	4						
	5						
	6						
	7						
	8						
	9						
	10						
	11						
	12						
	13						
	14						
	15						
	16						
	17						
	18						
	19						
	20						
	21						
	22						
	23						
	24						

SEWICKLEY VALLEY HOSPITAL
SEWICKLEY, PA.

CAT. #1-0108

BILLING DATES

\$ 5.00	SEWICKLEY, PENNSYLVANIA, 1/13/67
RECEIVED FROM M. _____	
Five <u>for 00</u>	DOLLARS
FOR PROFESSIONAL SERVICES	
AMOUNT OF ACCOUNT \$ 5.00	JOHN S. LIGGETT, M. D.
AMOUNT PAID \$ 5.00	JOSEPH B. GRIFFITH, M. D.
BALANCE \$	J. HOWARD CLARK, M. D.
	BY: <u>adw</u>

*Blanked out by Ways and Means Committee.



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

REQUEST FOR PAYMENT
MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT
(Type or Print all Information)

Form Approved
Budget Bureau No. 72-R730

00865

MEDICARE
PENNSYLVANIA BLUE SHIELD
BOX 65, CAMP HILL, PA. 17011

Copy from
your HEALTH
INSURANCE
CARD

NAME OF BENEFICIARY (Patient)

*

CLAIM NUMBER

168-09-9474-A

☒ MALE ☐ FEMALE

PART I—CLAIMS INFORMATION—TO BE COMPLETED BY PATIENT.

1. Describe the illness or injury for which you received treatment. (You do not need to complete this item if your doctor completes Part II below)

2. Was your illness or injury connected with your employment?

☐ YES ☒ NO

3. Are you attaching itemized receipted bills?

☒ YES ☐ NO

4. ASSIGNMENT: Do you want payment for an unpaid bill made directly to the physician or supplier?

☐ YES ☒ NO

AUTHORIZATION: I authorize release of any information required to act on this claim and permit a photographic or other facsimile reproduction of this authorization to be used in place of the original.

REQUEST FOR PAYMENT: I am requesting payment either to myself or to the party accepting my assignment for the medical insurance benefit, if any, payable for the reasonable charges for services or supplies described. Where payment is assigned, I understand I am responsible for the deductible and 20% of the remaining reasonable charges.

5. SIGNATURE (Patient or authorized representative)

*

DATE SIGNED

6. ADDRESS (Street address, City, State, ZIP Code)

11

* MONACA PA 15061

TELEPHONE NUMBER

774-0101

PART II—REPORT OF SERVICES—TO BE COMPLETED BY PHYSICIAN—

This Part, Including Physician's Signature, Need Not Be Completed If Paid, Itemized Bills Are Submitted.

7. A. DATE OF EACH SERVICE	B. PLACE OF SERVICE	C. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	D. NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES (Diagnosis)	E. CHARGES	Leave Blank
10-20-66	Physician's Office	Excision left great toenail Excision latently free subungual hemangioma great toe		\$	

8. NAME AND ADDRESS OF PHYSICIAN OR SUPPLIER (Number and street, City, State, ZIP Code)	TELEPHONE NUMBER	9. Total Charges	\$
	CODE NO.	10. Amount Paid	\$
		11. Any Unpaid Balance Due	\$

M R ZERNICH MD
20TH & MAIN STS
ALBUQUERQUE NM

ZERNMR20T

16064

12. ASSIGNMENT OF PATIENT'S BILL

☐ I ACCEPT ASSIGNMENT

☐ I DO NOT ACCEPT ASSIGNMENT

13. SIGNATURE OF PHYSICIAN OR SUPPLIER (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)

☐ MD ☐ DO ☐ DDS OR DMD

DATE SIGNED

10—Doctor's Office

11—Inpatient Hospital

ECF—Extended Care Facility

OL—Other Locations (Specify in 7C)

12—Independent Laboratory (give name and address in 7C)

H—Patient's Home

OH—Outpatient Hospital

NH—Nursing Home

STATEMENT

ESSEX 5-0111

STEPHEN ZERNICH, JR., M. D.
COR. 20TH & MAIN STREET
ALIQUIPPA, PA.

11/9/66

19

*

Monaca, Pa.

FOR PROFESSIONAL SERVICES:

10/20/66

Surgery

\$60.00

After we have been paid we will give you a receipt.
You can then submit this to Medicare.

12-7-66 Paid in full \$ 60.⁰⁰
rd.

PAID TO THE ORDER OF
MELLON NATIONAL BANK
75 AND TRUST COMPANY 75
DR. STEPHEN ZERNICH
DR. WALLACE ZERNICH
DR. MICHAEL R. ZERNICH

MAKE CHECKS PAYABLE TO ZERNICH CLINIC

STEPHEN ZERNICH, Jr., M. D.
WALLACE ZERNICH, M. D.
20th & MAIN STREET
ALIQUIPPA, PA. 15001
PHONE: 375-0111

Nº 5729

Dec. 7, 1966

RECEIVED OF *

Sixty-five and 08/10 0 ¹⁰ DOLLARS

FOR Surgery - 10-20-66 - Office call 12-7-66

\$ 65.⁰⁰

rd

11	DR. HARVEY E. THORPE 206 IROQUOIS BLDG. 3600 FORBES AVE. PHONE 682-4005	74186
	Pittsburgh, Pa., 15213	Aug 12 1966
RECEIVED OF *		
FOR Treatment of Eyes		
Amount Paid \$ 10.00		
Balance Due \$ —		
		By J. E. Bell PITTSBURGH SALESBOK CO., PITTSBURGH, PA.

15	DR. HARVEY E. THORPE 206 IROQUOIS BLDG. 3600 FORBES AVE. PHONE 682-4005	73318
	Pittsburgh, Pa., 15213	Aug 26 1966
RECEIVED OF *		
FOR Treatment of Eyes		
Amount Paid \$ —		
Balance Due \$ 10.00		
		By D. Hoffman PITTSBURGH SALESBOK CO., PITTSBURGH, PA.

23	DR. HARVEY E. THORPE 206 IROQUOIS BLDG. 3600 FORBES AVE. PHONE 682-4005	74025
	Pittsburgh, Pa., 15213	Oct 28 1966
RECEIVED OF *		
FOR Treatment of Eyes		
Amount Paid \$ 10.00		
Balance Due \$ —		
		By D. Hoffman PITTSBURGH SALESBOK CO., PITTSBURGH, PA.

*Blanked out by Ways and Means Committee.

PENNSYLVANIA BLUE SHIELD

CAMP HILL, PA. 17011

TITLE XVIII, SOCIAL SECURITY ACT.

BENEFICIARY'S NAME & ADDRESS

CHECK NO.

*

ALIQUPPA PA.

3040242

REPORT NUMBER	H. I. CLAIM NUMBER	DISPOSITION	DATE	YOUR \$50.00 DEDUCTIBLE HAS BEEN SATISFIED FOR THE YEAR INDICATED HERE →	
34406832	169101019A	ASSIGNED	122366	1966	
SERVICE DATES	PLACE OF SERVICE(S)	DESCRIPTION OF SERVICE(S)	TOTAL CHARGES	NOT ALLOWED *	CHARGES ALLOWED
100466	INPATIENT HOSPITAL	ANESTHESIA	3430		3430
100266	INPATIENT HOSPITAL	DIAGNOSTIC LAB	2113		2113
101766	INPATIENT HOSPITAL	DIAGNOSTIC LAB	250		250
100366	INPATIENT HOSPITAL	DIAGNOSTIC X-RAY	1750		1750
REMARKS			7543		7543

PROVIDERS OF SERVICES AND SUPPLIES

50.00	25.43	5.09	20.34	55.09			
DEDUCTIBLE PAYABLE BY BENEFICIARY	BALANCE OF ALLOWED CHARGES	LESS 20% PAYABLE BY BENEFICIARY	MEDICAL INSURANCE BENEFITS PAID	TOTAL PAYABLE BY BENEFICIARY	YOU HAVE ALREADY PAID	WE ARE PAYING YOU	AND DOCTOR OR SUPPLIER
					THE ABOVE BOXES WILL BE BLANK UNLESS YOU HAVE ALREADY MADE A PAYMENT ON YOUR BILL.		

PENNSYLVANIA BLUE SHIELD

CAMP HILL, PENNSYLVANIA 17011

60.82
313

FOR HEALTH INSURANCE — SOCIAL SECURITY ACT

CHECK NO. 3040242

MUST BE CASHED WITHIN 6 MONTHS

BENEFICIARY'S NAME & ADDRESS

DATE

PAY TO THE ORDER OF

*

12/23/66

PAY \$ 20 34

ALIQUPPA PA

 ROCHESTER GEN HOSP
 500 PINNEY ST
 ROCHESTER PA
FEDERAL HEALTH INSURANCE
BENEFITS ACCOUNTTHE HARRISBURG NATIONAL BANK AND TRUST CO.
HARRISBURG, PENNSYLVANIA

NON-NEGOTIABLE

*Blanked out by Ways and Means Committee.

WILLOW GROVE, PA. # 12900 1 2 3
FORM 3-64-0

REMOVE BEFORE DEPOSITING

REMOVE BEFORE DEPOSITING

NAME		PHONE	DATE	ROOM	RATE	HOSP. NO.		31-7604		31-ROCHESTER GENERAL		
ADDRESS		AGE	10/7/23	24	00	DATE-TIME DISCH.		10/7/60		115PM DISCH. HOSPITAL		
RELATIVE		DOCTOR D.R. Patrick & Dr. M. F. Taylor										
ADDRESS		EMPLOYER J & I Steel Co.										
AYOR Medication A & B 168-10-1019-A		OCCUPATION Retired										
POSTING DATE	ROOM	SPECIAL SERVICES	LABORATORY	RADIOLOGY	OTHER	PROF. SERVICES	MED.-SURG.-SUP.	MISCELLANEOUS	C R E D I T S	AMOUNT	CODE	BALANCE DUE
DATE	NO.	AMOUNT	CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT	CODE	
11/66	30.00	10										30.00
11/66	30.00	11										24.00
12/66	24.00	11										32.50
12/66	24.00	11										56.50
12/66	24.00	11										134.25
12/66	24.00	11										158.25
12/66	24.00	11										238.00
12/66	24.00	11										262.00
12/66	24.00	11										273.00
12/66	24.00	11										297.00
12/66	24.00	11										321.00
12/66	24.00	11										382.00
12/66	24.00	11										406.00
12/66	24.00	11										412.00
12/66	24.00	11										436.00
12/66	24.00	11										460.00
12/66	24.00	11										484.00
12/66	24.00	11										487.20
CORRECTED BALANCE												
15 72												
5.00 71												
2.75 72												
5.00 72												
50 72												
3.20												

*Blanked out by Ways and Means Committee.

#6
PENNSYLVANIA
CAMP HILL, PENNSYLVANIA 17011

MEDICAL SERVICE
ASSOCIATION
OF PENNSYLVANIA

PHONE:
(717) 236-9011

February 9, 1967

IN REPLY, WRITE TO
MEDICARE DEPARTMENT

*

Aliquippa, Penna.

HI Claim Number: 168-10-4573-A
Report Number:

*
Dear Mr.

The enclosed bill(s) were received by us, recently, with a Medicare Request for Payment form.

Pennsylvania Blue Shield, as a Medicare Part B carrier, processes Request for Payment forms only for physicians' services and medical supplies provided in Pennsylvania.

If the enclosed bill(s) are for physicians' services, we must have the name(s) of the doctor(s), dates of service, exact type of service and itemized charge for each service. Please have the hospital show this information on the bill(s).

After the above information is inserted on the bill(s) and the bill(s) are receipted, complete the enclosed Request for Payment, attach the receipted bill(s) and return to us for processing.

Medicare Claims Processing Department

bjb

Enclosure(s)

Please

*Blanked out by Ways and Means Committee.



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
00865

REQUEST FOR PAYMENT
MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT
(Type or Print all information)

Form Approved
Budget Bureau No. 72-R730

MEDICARE
PENNSYLVANIA BLUE SHIELD
BOX 65, CAMP HILL, PA. 17011

Copy from
your HEALTH
INSURANCE
CARD

NAME OF BENEFICIARY (Patient) *

CLAIM NUMBER

162-10-4573A ☒ MALE ☐ FEMALE

PART I—CLAIMS INFORMATION—TO BE COMPLETED BY PATIENT.

1. Describe the illness or injury for which you received treatment. (You do not need to complete this item if your doctor completes Part II below)

2. Was your illness or injury connected with your employment?

☐ YES ☒ NO

3. Are you attaching itemized receipted bills?

☒ YES ☐ NO

4. ASSIGNMENT: Do you want payment for an unpaid bill made directly to the physician or supplier?

☐ YES ☒ NO

AUTHORIZATION: I authorize release of any information required to act on this claim and permit a photographic or other facsimile reproduction of this authorization to be used in place of the original.

REQUEST FOR PAYMENT: I am requesting payment either to myself or to the party accepting my assignment for the medical insurance benefit, if any, payable for the reasonable charges for services or supplies described. Where payment is assigned, I understand I am responsible for the deductible and 20% of the remaining reasonable charges.

5. SIGNATURE (Patient or authorized representative)

DATE SIGNED

2/5/67

6. ADDRESS (Street address, City, State, ZIP Code)

* AVE. ALIQUIPPA, PA

TELEPHONE NUMBER

375-5749

PART II—REPORT OF SERVICES—TO BE COMPLETED BY PHYSICIAN—

This Part, Including Physician's Signature, Need Not Be Completed If Paid, Itemized Bills Are Submitted.

A. DATE OF EACH SERVICE	B. PLACE OF SERVICE	C. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	D. NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES (Diagnosis)	E. CHARGES	Leave Blank
		Receipts in amount of		\$ 115.00	
		are herewith attached.			

8. NAME AND ADDRESS OF PHYSICIAN OR SUPPLIER (Number and street, City, State, ZIP Code)	9. Total Charges	\$
	10. Amount Paid	\$
	11. Any Unpaid Balance Due	\$

S ZERNICH JR MD
20TH MAIN STS
ALIQUIPPA PA
ZERNS 20T
09389

12. ASSIGNMENT OF PATIENT'S BILL (See reverse)

☐ I ACCEPT ASSIGNMENT

☐ I DO NOT ACCEPT ASSIGNMENT

13. SIGNATURE OF PHYSICIAN OR SUPPLIER (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)

☐ MD ☐ DO ☐ DDS OR DMD

DATE SIGNED

IC—Doctor's Office

IH—Inpatient Hospital

ECF—Extended Care Facility

OL—Other Locations (Specify in 7C)

IL—Independent Laboratory (give name and address in 7C)

H—Patient's Home

OH—Outpatient Hospital

NH—Nursing Home

FORM SSA-1490 (4-66)

*Blacked out by Ways and Means Committee.

STEPHEN ZERNICH, Jr., M. D.
WALLACE ZERNICH, M. D.
20th & MAIN STREET
ALIQUIPPA, PA. 15001
PHONE: 375-0111

Nº 6212

_____, 7/2, 1966

*
RECEIVED OF _____

Five _____ DOLLARS

For Office call _____

\$ 5.00 _____ bc. _____

STEPHEN ZERNICH, Jr., M. D.
WALLACE ZERNICH, M. D.
20th & MAIN STREET
ALIQUIPPA, PA. 15001
PHONE: 375-0111

Nº 6142

_____, 7.22, 1966

*
RECEIVED OF _____

Five _____ DOLLARS

For OC & Y. _____

\$ 5.00 _____ N.S. _____

*Blanked out by Ways and Means Committee.

SIDNEY N. BUSIS, M.D.
3500 FIFTH AVENUE
PHONE: 681-7755
PITTSBURGH, PENNSYLVANIA 15213

DATE 8/16/66 No. 5851

Received from Mr. * Dollars \$ 10.00

In re: Ten

AMOUNT OF ACCT \$
AMOUNT PAID \$ 10.00
BALANCE DUE \$
CASH ☒ CHECK ☐ M.O. ☐

SIDNEY N. BUSIS, M.D.
By A. Slavov
THANK YOU

SIDNEY N. BUSIS, M.D.
3500 FIFTH AVENUE
PHONE: 681-7755
PITTSBURGH, PENNSYLVANIA 15213

DATE 8/16/66 No. 5804

Received from Mr. * Dollars \$ 5.00

In re: Ten

AMOUNT OF ACCT \$
AMOUNT PAID \$ 5.00
BALANCE DUE \$
CASH ☒ CHECK ☐ M.O. ☐

SIDNEY N. BUSIS, M.D.
By B. Smille
THANK YOU

ALIQUIPPA HOSPITAL
Aliquippa, Pa.

No. OP 18244

Date 7-21-1966
CASH ☒ M.O. ☐ CHECK ☐ MISC ☐

AMOUNT \$2.00 DOLLARS
RECEIVED FROM Joe
SERVICE E.P.

ALIQUIPPA HOSPITAL

CASH RECEIPT

by W. Zornish
We Acknowledge with Thanks Receipt of Amount Shown.

ALIQUIPPA HOSPITAL
Aliquippa, Pa.

No. OP 17682

Date 6-15-66
CASH ☒ M.O. ☐ CHECK ☐ MISC ☐

AMOUNT \$9.00 DOLLARS
RECEIVED FROM Gene Orleans
SERVICE Lab

ALIQUIPPA HOSPITAL

CASH RECEIPT

by MS
We Acknowledge with Thanks Receipt of Amount Shown.

ALIQUIPPA HOSPITAL
Aliquippa, Pa.

No. OP 18121

Date 7-14-66
CASH ☒ M.O. ☐ CHECK ☐ MISC ☐

AMOUNT \$9.00 DOLLARS
RECEIVED FROM Mr. Orleans
SERVICE Lab.

ALIQUIPPA HOSPITAL

CASH RECEIPT

by MS
We Acknowledge with Thanks Receipt of Amount Shown.

*Blanked out by Ways and Means Committee.

STATEMENT

ESSEX 5-0111

STEPHEN ZERNICH, JR., M. D.
COR. 20TH & MAIN STREET
ALIQUIPPA, PA.

July 22, 1966

*

Avenue

Aliquippa, Pa.

FOR PROFESSIONAL SERVICES:

Balance due

\$10.00

9-16-66 Paid in full
1961

10.00

9-16-66
1961
PAID STATEMENT

MAKE CHECKS PAYABLE TO ZERNICH CLINIC

Statement

Phone: 375-0111

WALLACE ZERNICH, M. D.
Cor. 20th & Main Streets
ALIQUIPPA, PA. 15001

August 29, 1966

*

Avenue

Aliquippa, Pa.

FOR PROFESSIONAL SERVICES:

Balance SZ
X Balance WZ

\$10.00
X 50.00

Balance due

-\$60.00

9-16-66 Paid in full
1961

9-16-66
1961
PAID STATEMENT

*Blanked out by Ways and Means Committee.

EXPLANATION OF OUTPATIENT HOSPITAL BENEFITS
 MEDICAL INSURANCE (Title XVIII, Social Security Act)

BLUE CROSS OF WESTERN PENNSYLVANIA

HEALTH INSURANCE CLAIM
NUMBER

DATE

 P. O. BOX 1465
 PITTSBURGH, PA. 15230

168-10-4573 A

12-16-66

 NAME AND ADDRESS OF THE BENEFICIARY
 OR REPRESENTATIVE OF THE BENEFICIARY

NAME AND ADDRESS OF HOSPITAL

 *
 Aliquippa, Pa. 15001

 Aliquippa Hospital
 Aliquippa, Pa. 15001

The bill for OUTPATIENT HOSPITAL services described below was recently submitted under your health insurance claim number.

DATE OF EACH SERVICE	DESCRIPTION OF SERVICES	TOTAL CHARGES	COVERED CHARGES	NON-COVERED CHARGES
7-23-66	Examination	10.00	10.00	
TOTALS		\$ 10.00	\$ 10.00	\$
Less physician charges included in totals			\$	
TOTAL COVERED CHARGES for this bill			\$ 10.00	

The computation of MEDICAL INSURANCE benefits for this bill is shown below. The amount shown in the "You Paid Hospital" column is the amount you had paid for outpatient hospital services at the time the hospital submitted your claim for our review. The figure shown does not include any amount you paid the hospital for physicians' services, nor does it include any amount paid by you after your claim left the hospital.

\$ 10.00	\$ 14.00	\$ none	\$ --	\$ none	\$ 10.00	\$	\$
TOTAL COVERED CHARGES	DEDUCTIBLE PAYABLE BY BENEFICIARY	BALANCE OF COVERED CHARGES	LESS 20% PAYABLE BY BENEFICIARY	MEDICAL INSURANCE BENEFITS	TOTAL PAYABLE BY BENEFICIARY	YOU PAID HOSPITAL	REFUND (Enclosed)
						The above boxes will be blank unless you paid hospital for part of bill.	

REMARKS:

See paragraph #2 on back of notice

DEDUCTIBLE STATUS AS OF DATE OF THIS NOTICE:

You have incurred \$ 10.00 toward the deductible for this calendar year.

PLEASE READ THE OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION

PENNSYLVANIA

CAMP HILL, PENNSYLVANIA 17011

MEDICAL SERVICE
ASSOCIATION
OF PENNSYLVANIAPHONE:
(717) 236-9011

February 9, 1967

IN REPLY, WRITE TO
MEDICARE DEPARTMENT*
Avenue
Aliquippa, Penna.HI Claim Number: 168-10-4573-A
Report Number:

Dear Mr. Koza:

The enclosed bill(s) were received by us, recently, with a Medicare Request for Payment form.

Pennsylvania Blue Shield, as a Medicare Part B carrier, processes Request for Payment forms only for physicians' services and medical supplies provided in Pennsylvania.

If the enclosed bill(s) are for physicians' services, we must have the name(s) of the doctor(s), dates of service, exact type of service and itemized charge for each service. Please have the hospital show this information on the bill(s).

After the above information is inserted on the bill(s) and the bill(s) are receipted, complete the enclosed Request for Payment, attach the receipted bill(s) and return to us for processing.

Medicare Claims Processing Department

bjb

Enclosure(s)

*Blanked out by Ways and Means Committee.

Mr. .
Avenue
Aliquippa, Pa.

EXHIBIT
#7

[illegible]

CODE - GP - 1ST OFFICE CALL NO - HOUSE CALL H - HOSPITAL CARE
 OO - OFFICE CALL ECG - ELECTROCARDIOGRAM

PENNSYLVANIA BLUE SHIELD

CAMP HILL, PA. 17011



NOTICE OF CLAIM PAYMENT

THIS PAYMENT IS PROOF OF THE VALUE OF YOUR BLUE SHIELD PROTECTION. NEARLY 2 MILLION OTHER PAYMENTS WILL BE MADE ON BEHALF OF PENNSYLVANIA BLUE SHIELD MEMBERS THIS YEAR.

SUBSCRIBER OR DOCTOR:

13409

ALQUIPPA AVE
PA

PAYMENT WAS MADE TO:

MO. DAY YR.

11 10 66

CLAIM NO.

6580976

E A HUMPHREYS MD
235 SUNSET RD
PITTSBURGH 37 PA

AREA	AGREEMENT NO.	PATIENT'S NAME	DATE OF SERVICE			PLAN	SERVICE
			MO.	DAY	YR.		
A	209013551	*	8	10	66	A	SURGERY AND MEDICAL

\$92.00

230 D 8/87

IF YOU HAVE ANY QUESTIONS ABOUT THIS PAYMENT, PLEASE SEND THIS NOTICE TO BLUE SHIELD WITH YOUR INQUIRY. WE WILL RETURN IT WITH OUR REPLY.

WAS PAID BY
BLUE SHIELD

*Blanked out by Ways and Means Committee.

Health Insurance	SOCIAL SECURITY ACT	NAME OF BENEFICIARY *	SEX	CLAIM NUMBER	IS ENTITLED TO	EFFECTIVE DATE
			MALE	209-01-3551-A	HOSPITAL INSURANCE	7-1-66
					MEDICAL INSURANCE	7-1-66
					SIGN HERE	<i>W. H. Ford</i>

OFFICE HOURS
BY APPOINTMENT
MONDAY THROUGH SATURDAY

PHONE
391-1890

Nov. 4, 1966

EARL A. HUMPHREYS, M. D.
235 SUNSET RD.
PITTSBURGH, PA. 15237

Mr. *

Live.

Aliquippa, Pa.

FOR PROFESSIONAL SERVICES

\$ 191.00

Hospital care 8/10/66 to 8/27/66 \$105.00
Gastroscopy 8/11/66 \$50.00
Cytology 8/12/66 \$15.00
Office visit 5 FU 9/9/66 \$7.00
Office visit 9/16/ 5 FU \$7.00
Office visit 9/23/66 \$7.00
This account was sent to Blue Shield.
9/9/66 and no reply has been received.

RECEIVED PAYMENT

For billing information please call 364-4136

IDENTIFICATION CARD		
BLUE CROSS OF WESTERN PENNSYLVANIA		
ONE SMITHFIELD STREET, PITTSBURGH, PA. 15222		
NAME *	ACC.	SP
GROUP NUMBER	AGREEMENT NUMBER	DATE OF PRES. ASMT.
62007-02	209-01-3551A	07-01-66
MASTER - MEDICARE SUPPLEMENTAL		
The above named person is entitled to such benefits as provided by the Agreement under which he or she is enrolled. Hospitals are authorized to render services subject to verification by this office.		
<i>William H. Ford</i> William H. Ford, President		

IDENTIFICATION CARD	
PENNSYLVANIA BLUE SHIELD	
GROUP NO.	AGREEMENT NO.
62007-02	209-01-3551A
TYPE OF MEMBERSHIP	
MASTER	
07-01-66 EFFECTIVE DATE	
The above named person is entitled to such benefits as provided by the Agreement under which he or she is enrolled.	
Executive Offices Camp Hill, Pennsylvania	<i>M. J. Sale</i> Executive Vice-President

*Blanked out by Ways and Means Committee.

PATIENT'S CASH RECEIPT

ALLEGHENY GENERAL HOSPITAL PITTSBURGH, PA. CASH RECEIPT

No. 11661

OUT
PATIENT
 TYPE OF REMITTANCE (Check ☒ One)
 CASH ☒ MONEY ORDER ☐ CHECK ☐
IN
PATIENT

RECEIVED FROM *

DATE

FOR ACCOUNT OF *

8-10-66

REGISTER NO.

702139-7

AMOUNT

\$ 40.00 Forty & No/100

PERSON
RECEIVING
PAYMENT

New admission

pk

We acknowledge with thanks receipt of amount printed hereon which has been credited to your account.

Health Insurance

SOCIAL SECURITY ACT

NAME OF BENEFICIARY

GR. # 62007-2

CLAIM NUMBER

209-01-3551-A

SEX

MALE

IS ENTITLED TO

EFFECTIVE DATE

HOSPITAL INSURANCE 7-1-66

MEDICAL INSURANCE 7-1-66

SIGN
HERE

Ali Mohamed

*Blanked out by Ways and Means Committee.



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

REQUEST FOR PAYMENT
MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT
(Type or Print all information)

Form Approved
Budget Bureau No. 72-2200

Copy from
your HEALTH
INSURANCE
CARD

NAME OF BENEFICIARY (Print)

CLAIM NUMBER

168-10-0265

☒ MALE ☐ FEMALE

PART I—CLAIMS INFORMATION—TO BE COMPLETED BY PATIENT.

1. Describe the illness or injury for which you received treatment. (You do not need to complete this item if your doctor completes Part II below)

UMOR

2. Was your illness or injury connected with your employment?

☐ YES ☒ NO

3. Are you attaching itemized receipted bills?

☐ YES ☒ NO

4. ASSIGNMENT: Do you want payment for an unpaid bill made directly to the physician or supplier?

☐ YES ☒ NO

AUTHORIZATION: I authorize release of any information required to act on this claim and permit a photographic or other facsimile reproduction of this authorization to be used in place of the original.

REQUEST FOR PAYMENT: I am requesting payment either to myself or to the party accepting my assignment for the medical insurance benefit, if any, payable for the reasonable charges for services or supplies described. Where payment is assigned, I understand I am responsible for the deductible and 20% of the remaining reasonable charges.

5. SIGNATURE (Patient or authorized representative)

DATE SIGNED

6. ADDRESS (Street address, City, State, ZIP Code)

TELEPHONE NUMBER

U. Aliquippa, Pa.

PART II—REPORT OF SERVICES—TO BE COMPLETED BY PHYSICIAN—

This Part, including Physician's Signature, Need Not Be Completed If Paid, Itemized Bills Are Submitted.

7. A. DATE OF EACH SERVICE	B. PLACE OF SERVICE ¹	C. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	D. NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES (Diagnosis)	E. CHARGES	Leave Blank
8/19/66	Pgh. Pa.	See Receipt.		\$ 200.00	
8/17/66	Pgh. Pa.	See Receipt.		40.00	
8/13/66	Sewickly Pa.	See Receipt.		20.00	
7/19/66	Aliquippa	See Receipt.		10.00	
7/19/66	Aliquippa	See Receipt.		5.00	
8. NAME AND ADDRESS OF PHYSICIAN OR SUPPLIER (Number and street, City, State, ZIP Code)			TELEPHONE NUMBER	9. Total Charges	\$ 275.00
			CODE NO.	10. Amount Paid	\$ 275.00
				11. Any Unpaid Balance Due	\$

12. ASSIGNMENT OF PATIENT'S BILL
(See reverse)

☐ I ACCEPT ASSIGNMENT

☐ I DO NOT ACCEPT ASSIGNMENT

13. SIGNATURE OF PHYSICIAN OR SUPPLIER (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)

☐ MD ☐ DO ☐ DDS
OR
☐ DMD

DATE SIGNED

¹O—Doctor's Office

IH—Inpatient Hospital

ECF—Extended Care Facility

OL—Other Locations (Specify in 7C)

IL—Independent Laboratory (give name and address in 7C)

H—Patient's Home

OH—Outpatient Hospital

NH—Nursing Home

DOCTORS OFFICES
UNIVERSITY HEALTH CENTER106 LOTHROP STREET
PITTSBURGH, PENNSYLVANIA 15213PHONE 683-1620
EXT. 611

October 18 19 66

Mr. *
St.
Aliquippa, Pennsylvania

Please tear off and return with your remittance to insure proper credit.
Itemized statement will be furnished, if requested.

FOR PROFESSIONAL SERVICES (Rendered by Dr. Henry T. Bahnsen)

age: 74

Professional Fee:
(Surgery performed at Presbyterian-
University Hospital on 8-19-66)

\$200.00

OPERATION: Removal of left renal cyst.

PAID

10/18/66 A.C.
DOCTORS OFFICES

Please make checks payable to Doctors Offices and mail to:
University Health Center, 106 Lothrop Street, Pittsburgh, Pennsylvania 15213

108

*Blanked out by Ways and Means Committee.

PRESBYTERIAN - UNIVERSITY HOSPITAL

230 Lothrop Street
Pittsburgh, Pennsylvania 15213
Phone: 682-8100

CASH RECEIPTDate 8-17-66

Rec'd of: _____

Acct of: _____

Acct # <u>46937</u>	Accommodation		
\$ <u>40.00</u>	Cash ☒	Check ☐	Other ☐

Remarks: New Admission

Classification of Account			
In House ☒	Disch ☐	OP ☐	ER ☐

We have endeavored to have all charges included in your bill. A later statement may be sent to cover charges or credits not recorded at this time.

RECEIPT # **32925**Cashier *[Signature]*

Thank You

ALLEGHENY TYPEWRITER CO., PITTSBURGH, PA. ED 75114 0-322564-U

*Blanked out by Ways and Means Committee.

STATEMENT

Practice Limited To
Orthopaedic Surgery

MICHAEL R. ZERNICH, M. D.

COR. 20th & MAIN STREETS
ALQUIPPA, PA. 15001

Telephone 375-0111

July 19, 1966

*

Street

Aliquippa, Pa.

FOR PROFESSIONAL SERVICES:

6/6/66
7/12/66

x-ray left foot
Blue shield paid

\$10.00
5.00

Balance due

\$5.00

7/25/66 Paid in full \$5.00 (cc)

FINAL STATEMENT

ALQUIPPA HOSPITAL

Aliquippa, Pa.

No. OP 17554

Date 6-6-66 19

CASH	M O	CHECK
☒	☐	☐

OP	IP	MISC
☒	☐	☐

FOR ACCOUNT OF *

\$ 5.00

AMOUNT

Five Dollars

DOLLARS

RECEIVED FROM

Lol

SERVICE

W Zernich

CASH RECEIPT

ALQUIPPA HOSPITAL

by M S.

We Acknowledge with Thanks Receipt of Amount Shown.

* Blanked out by Ways and Means Committee.

M. PRINCETON NADLER, M. D.

ROBERT J. PAVLIS, M. D.

401 BROAD STREET

SEWICKLEY, PA.

PHONE 741-8920

7072

DATE *Aug 12 1967*

PLEASE PRESENT AT DESK

PATIENT: *223 **BILL TO: *William J. Paul*

1 - REFRACTION	<i>20.50</i>	PREVIOUS BALANCE	~~XX~~
2 - OFFICE CALL		TODAY'S CHARGE	<i>20</i> ^{<i>00</i>}
3 - CONSULTATION		PAID TODAY	<i>20</i> ^{<i>00</i>} <i>(C)</i>
4 - SURGERY		BALANCE	<i>(C)</i>
5 - COMPENSATION			
6 - GLASSES			
7 - REPAIRS			
8 - MISC.			
9 -			

Please Give Us 24 Hours Advance Notice
If You Cannot Keep This Appointment

NEXT APPOINTMENT

DATE _____ TIME _____

*Blanked out by Ways and Means Committee.

STATEMENT

ESSEX 5-0111

STEPHEN ZERNICH, JR., M. D.

COR. 20TH & MAIN STREET

ALIQUIPPA, PA.

July 19, 1966

*

Street

Aliquippa, Pa.

FOR PROFESSIONAL SERVICES:

7/18/66	Office call & treatment	\$5.00
---------	-------------------------	--------

7/25/66 Paid in full \$5.00
(bc)

FINAL STATEMENT

MAKE CHECKS PAYABLE TO ZERNICH CLINIC

*Blanked out by Ways and Means Committee.

Wants to know if this can be
paid by medicare? #9
EXHIBIT

ESSEX 5-0111

STATEMENT

375-1894

STEPHEN ZERNICH, JR., M. D.
COR. 20TH & MAIN STREET
ALQUIPPA, PA.

September 7, 1966

378-1894

*
*
Street
Aliquippa, Pa.

FOR PROFESSIONAL SERVICES:

7/22/66

Surgery

\$150.00

After we have been paid we will give you a receipt
You can then turn this into Medicare.

FINAL STATEMENT

MAKE CHECKS PAYABLE TO ZERNICH CLINIC

*Blanked out by Ways and Means Committee.

EXHIBIT #10

PENNSYLVANIA BLUE SHIELD		CAMP HILL, PA. 17011		EXPLANATION OF BENEFITS—MEDICAL INSURANCE TITLE XVIII, SOCIAL SECURITY ACT.	
BENEFICIARY'S NAME & ADDRESS				CHECK NO.	
REPORT NUMBER		H. I. CLAIM NUMBER		ALIQUPPA PA	
32000813		168104588A		7017564	
DISPOSITION		DATE		YOUR \$50.00 DEDUCTIBLE HAS BEEN SATISFIED FOR THE YEAR INDICATED HERE.	
NON-ASSIGNED		12/05/66		1966	
SERVICE DATES	PLACE OF SERVICE(S)	DESCRIPTION OF SERVICE(S)	TOTAL CHARGES	CHARGES NOT ALLOWED *	CHARGES ALLOWED
10/17/66	INPATIENT HOSPITAL	MEDICAL CARE	131.00		131.00
11/09/66	OFFICE	MEDICAL CARE	7.00		7.00
REMARKS			138.00		138.00
PROVIDERS OF SERVICES AND SUPPLIES D C BENNIGHOF MD D C BENNIGHOF MD					
50.00	88.00	17.60	70.40	67.60	138.00
DEDUCTIBLE PAYABLE BY BENEFICIARY	BALANCE OF ALLOWED CHARGES	LESS 20% PAYABLE BY BENEFICIARY	MEDICAL INSURANCE BENEFITS PAID	TOTAL PAYABLE BY BENEFICIARY	YOU HAVE ALREADY PAID
					WE ARE PAYING YOU
					AND DOCTOR OR SUPPLIER
					THE ABOVE BOXES WILL BE BLANK UNLESS YOU HAVE ALREADY MADE A PAYMENT ON YOUR BILL.
PENNSYLVANIA BLUE SHIELD					
CAMP HILL, PENNSYLVANIA 17011					
[[					
FOR HEALTH INSURANCE — SOCIAL SECURITY ACT					
BENEFICIARY'S NAME & ADDRESS			DATE	CHECK NO. 0017564	
* 12/05/66			PAY TO THE ORDER OF		MUST BE CASHED WITHIN 6 MONTHS
ALIQUPPA PA			ALIQUPPA PA		PAY \$ 70.40
THE HARRISBURG NATIONAL BANK AND TRUST CO. HARRISBURG, PENNSYLVANIA					FEDERAL HEALTH INSURANCE BENEFITS ACCOUNT
m K Gale AUTHORIZED SIGNATURE					
00					
00017564 0313 0082 702 226 20					

REMOVE BEFORE DEPOSITING

1000

WILLOW GARDEN, PA. 17206-123

FORM 100-10-66

*Blanked out by Ways and Means Committee.



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
00865

REQUEST FOR PAYMENT
MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT
(Type or Print all information)

Form Approved
Budget Bureau No. 72-R710

MEDICARE
PENNSYLVANIA BLUE SHIELD
BOX 65, CAMP HILL, PA. 17011

Copy from
your HEALTH
INSURANCE
CARD

NAME OF BENEFICIARY (Print)

CLAIM NUMBER

☐ MALE ☒ FEMALE

PART I—CLAIMS INFORMATION—TO BE COMPLETED BY PATIENT.

1. Describe the illness or injury for which you received treatment. (You do not need to complete this item if your doctor completes Part II below)

2. Was your illness or injury connected with your employment?

☐ YES ☒ NO

3. Are you attaching itemized receipted bills?

☐ YES ☐ NO

4. ASSIGNMENT: Do you want payment for an unpaid bill made directly to the physician or supplier? ☒ YES ☐ NO

AUTHORIZATION: I authorize release of any information required to act on this claim and permit a photographic or other facsimile reproduction of this authorization to be used in place of the original.

REQUEST FOR PAYMENT: I am requesting payment either to myself or to the party accepting my assignment for the medical insurance benefit, if any, payable for the reasonable charges for services or supplies described. Where payment is assigned, I understand I am responsible for the deductible and 20% of the remaining reasonable charges.

5. SIGNATURE (Patient or authorized representative)

DATE SIGNED

2-15-67

6. ADDRESS (Street address, City, State, ZIP Code)

TELEPHONE NUMBER

774 8105

Rochester, Pa.

PART II—REPORT OF SERVICES—TO BE COMPLETED BY PHYSICIAN—

This Part, including Physician's Signature, Need Not Be Completed If Paid, Itemized Bills Are Submitted.

7. A. DATE OF EACH SERVICE	B. PLACE OF SERVICE	C. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	D. NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES (Diagnosis)	E. CHARGES	Leave Blank
1-3-67	IH	rectal ulcer; internal, external hemorrhoids Hemorrhoidectomy, internal, external Anal Sphincterotomy		\$ 137.50	
8. NAME AND ADDRESS OF PHYSICIAN OR SUPPLIER (Number and street, City, State, ZIP Code)			TELEPHONE NUMBER	9. Total Charges	\$ 137.50
J H SHUGERT MD 262 CONNECTICUT AVE ROCHESTER PA			775 1100	10. Amount Paid	\$ 50.00
SHUGJH262			CODE NO. 07690	11. Any Unpaid Balance Due	\$ 87.50

12. ASSIGNMENT OF PATIENT'S BILL

☒ I ACCEPT ASSIGNMENT

☐ I DO NOT ACCEPT ASSIGNMENT

13. SIGNATURE OF PHYSICIAN OR SUPPLIER (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)

☒ MD ☐ DO ☐ DDS OR DMD

DATE SIGNED

2-15-67

10—Doctor's Office

IH—Inpatient Hospital

ECF—Extended Care Facility

OL—Other Locations (Specify in 7C)

11—Independent Laboratory (give name and address in 7C)

H—Patient's Home

OH—Outpatient Hospital

NH—Nursing Home

ACCOUNT NUMBER

192 40 2746

COUNTY-DISTRICT

Beaver - 140ch.

RECORD NAME

CASE NUMBER

60050 TA

WE HAVE REVIEWED THE MEDICAL ASSISTANCE REQUEST FOR SERVICE DATED 1-2-67 FOR THE PATIENT NAMED BELOW.

NAME AND ADDRESS OF PATIENT

Rochester, Pa. 15074

Given below is our decision on the patient's eligibility. If it is not understood why this action was taken, or if there is any question regarding the decision, a staff member of the County Board of Assistance will be glad to explain. If the decision is not satisfactory, the patient or his representative has the right to a hearing.

Date 1-26-67

Signature _____

M. Ruth Batshelov
(COUNTY BOARD OF ASSISTANCE)

☒ ELIGIBLE - The patient is eligible for:

☒ INPATIENT HOSPITAL CARE FOR \$40.00 DAILY Deductible
☐ PRIVATE NURSING HOME CARE FOR DAYS @ \$ PER DAY

HOME NURSING CARE: ORDERS

☐ HOSPITAL HOME CARE
☐ PUBLIC NURSING HOME CARE
☐ MENTAL INSTITUTION CARE
☐ SPECIAL SERVICES FOR SCHOOL CHILDREN

TYPE PAYMENT

☒ FULL PAYMENT☐ PART PAYMENT-THE DEPARTMENT WILL PAY ONLY THAT PART OF THE BILL WHICH IS OVER \$_____

That part of the bill which is not paid by the Department is the responsibility of the patient or his relatives.

Patient's Share \$ _____ Relative's Share \$ _____ (See below)

NAME AND ADDRESS OF RELATIVE	RELATIONSHIP	AMOUNT

☐ **INELIGIBLE** - The reason the patient is not eligible is:

RESIDENCE

☐ NO MORE BENEFIT DAYS

☐ INCOME

ASSETS

☐ OTHER (Explain) _____

NAME AND ADDRESS OF HOSPITAL, INSTITUTION, AGENCY, ETC.

Rochester General Hospital
Rochester, Pa.

cc: Blue Cross

Commonwealth of Pennsylvania

Department of Public Welfare

PA 5M - 1-66

COMMONWEALTH OF PENNSYLVANIA		DEPARTMENT OF PUBLIC WELFARE	
IDENTIFICATION CARD MEDICAL ASSISTANCE			
issued to: *		Date:	
		1-30-67	
COUNTY	CASE NUMBER	NOT VALID AFTER	
Beaver	60050 TA	1-29-68	

SHOW CARD TO THE HOSPITAL, NURSE OR NURSING HOME WHEN YOU WANT MEDICAL ASSISTANCE.

STATEMENT

OFFICE HOURS
BY APPOINTMENTTELEPHONE
SPRUCE 5-1100J. G. M. WEYAND, M. D.
J. H. SHUGERT, M. D.
202 CONNECTICUT AVE.
ROCHESTER, PA.J. G. M. WEYAND, M. D.
J. H. SHUGERT, M. D.
202 CONNECTICUT AVE.
ROCHESTER, PA.

Rochester, Pennsylvania

Rochester, Pennsylvania

TEAR OFF AND RETURN THIS STUD WITH PAYMENT

DATE	PROFESSIONAL SERVICE	CHARGE	PAID	BALANCE
2-8-67	Surgery 1-3-67	137.50		137.50

Medicare Patients

We are using the "direct billing method".

When we receive your payment we will complete the necessary forms and you will be reimbursed by the insurance carrier.

PAY LAST
AMOUNT IN
THIS COLUMN

TEAR OFF AND RETURN THIS STUD WITH PAYMENT

DATE	PROFESSIONAL SERVICE	CHARGE	PAID	BALANCE
2-8-67	Surgery 1-3-67	137.50		137.50
2-15-67	by check		50.00	87.50

PAY LAST
AMOUNT IN
THIS COLUMN

*Blanked out by Ways and Means Committee.

EXHIBIT 12

[FROM WMBA, AMBRIDGE, PA., MINERS BROADCASTING SERVICE, INC., OCT. 20, 1966]

Anner: "The operation of the Medicare program in Aliquippa came under attack at the Local 12-11 meeting last night. Here to report is Roy Angst:

R.E.: "Medicare, as it is operating in the Aliquippa area, is for the birds! That is the opinion of one prominent union officials and he said so today in even stronger words and the membership of U.S.W. Local 1211 agrees. Mike Zahorsky, financial secretary of 1211, outlined the problems aged people are having with the program to the membership of the J & L local last night, and the union directed Zahorsky to take action to improve the situation—either by consultation with the medical profession, or by registering a complaint with the area's congressmen. Zahorsky explained the problem this way: The doctors have two ways to collect their money under Medicare. One way is to collect directly from the patient, then give the patient a request for payment form to fill out and send to the government. The second way is for the doctor to fill out this form and collect from the government. Doctors in the Aliquippa area, said Zahorsky, have chosen to collect directly from the patient and this has worked a hardship on many aged patients. First, said Zahorsky, the oldsters don't have four or five hundred dollars lying around the house and he feels the doctors are in a better position to wait for the money. Secondly, the pensioners are not familiar with filling out such extensive forms as the request for payment. Zahorsky said it takes a Philadelphia lawyer with the help of the President of the Medical Society to fill out the form properly. And too, said Zahorsky, sometimes the doctors collect from the patient, but the refund from the government is much less than the doctor's bill. Zahorsky feels the doctors are taking advantage of the medicare program to charge higher prices than they did when they accepted the Blue Shield allowance as total payment. Although 1211 has very extensive community services, the union feels they can not undertake to be the agent for the Federal government and the medical profession. The first step will be to ask the doctors to stop their present manner of making collections and to fill out the forms themselves."

Mr. ZAHORSKY. Are there any questions that you or the committee would care to ask of me?

The CHAIRMAN. Not at this point, Mr. Zahorsky. We do appreciate your being here very much.

Mr. ZAHORSKY. Do my colleagues, Mr. Brummit, or Mr. Polombo, have anything you want to add to what we have presented?

Thank you then for hearing us.

The CHAIRMAN. Without objection the committee will adjourn until 10 o'clock in the morning.

(Whereupon, at 12:57 p.m. the committee adjourned to reconvene at 10 a.m., Wednesday, March 8, 1967.)

PRESIDENT'S PROPOSALS FOR REVISION IN THE SOCIAL SECURITY SYSTEM

WEDNESDAY, MARCH 8, 1967

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met, pursuant to notice, at 10 a.m., in the committee room, Longworth House Office Building, Hon. Wilbur D. Mills (chairman of the committee) presiding.

The CHAIRMAN. The committee will please be in order.

This morning we have as our first witnesses a group at the table representing the American Hospital Association. Who is to be your leadoff witness? Mr. Cartmill?

STATEMENTS OF GEORGE CARTMILL, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION; ACCOMPANIED BY RAY R. EPPERT; WILLIAM MUELLER; MARK BERKE; DR. GEORGE W. GRAHAM; DR. EDWIN L. CROSBY, EXECUTIVE VICE PRESIDENT; KENNETH WILLIAMSON, ASSOCIATE DIRECTOR; ROBERT E. LINDE, DIRECTOR, DIVISION OF FINANCE; WILLIAM FREITAG; JOHN R. STAGL; GUSTAV A. KILLENBERG; AND GEORGE TEBBEL

Mr. CARTMILL. Yes, sir.

The CHAIRMAN. All right, Mr. Cartmill. Will you introduce yourself for the record by giving us your name, address, and capacity in which you appear? It might save time, since the others are also to testify, if you would identify them for the record now. Then you may yield to them as you see fit.

STATEMENT OF GEORGE CARTMILL, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. CARTMILL. Thank you, sir.

Mr. Chairman, I am George Cartmill. I am president and chief executive officer of Harper Hospital in Detroit, Mich. I would like at this time to name the other individuals who are here in behalf of the American Hospital Association and those who will present statements will introduce themselves more fully at the time they make their statements.

They are: Mr. Ray R. Eppert, who will speak to you as a hospital trustee, and who is a nationally and internationally known business and industry figure. We have Mr. William Mueller, a partner at

Arthur Andersen & Co., who is a nationally known public accounting authority and who will discuss detailed financing of hospital care, along with Mr. John R. Stagl, director of Passavant Memorial Hospital of Chicago; Mr. Mark Berk, director of Mount Zion Hospital and Medical Center of San Francisco, who will discuss the operation of the medicare program and particularly the financial impact of the program; Dr. George W. Graham, director of Ellis Hospital in Schenectady, N.Y., who will discuss how medicare is working in hospitals and particularly in respect to hospital physician relationships and outpatient care; Dr. Edwin L. Crosby, executive vice president of the American Hospital Association, who will summarize the recommendations of the association in respect to H.R. 5710.

And with us also are Kenneth Williamson, associate director of the American Hospital Association and director of its Washington service bureau and Robert E. Linde, director of the division of finance of the American Hospital Association.

The CHAIRMAN. We appreciate having all of you gentlemen with us this morning and, Mr. Cartmill, you are recognized, sir.

Mr. CARTMILL. Thank you, sir. We thought it would be helpful also to the Committee to obtain individual comments and observations from representatives of several nationally known public accounting firms, and with us are: Mr. George Tebbel, partner, Ernst & Ernst; Mr. Gustav A. Killenberg, a partner of Harris, Kerr, Forster, & Co., and Mr. William Freitag, a partner of Peat, Marwick, Mitchell & Co., all of whom will be pleased to participate in the discussion and to be of any possible help to the committee. All of these gentlemen are very knowledgeable in the field of hospital finance and hospital accounting.

I appear here today in behalf of the American Hospital Association as the elected president of that organization. The membership of the American Hospital Association is deeply involved in the implementation of the medicare law.

We appreciate greatly the opportunity of arranging for various individuals to appear here today to present specific aspects of our concerns with the program. We recognize, as I know you do, that the participation of hospitals is vital to the implementation of the law. We feel, therefore, that the views of hospitals in light of the experience we have now had will be of importance to you in considering any changes in the medicare law. The various individuals appearing here today in behalf of the association will present what we feel are significant matters for your consideration.

I would impress upon you that none of us is here to condemn medicare or belittle its accomplishments. We are here to present and discuss ways and means for strengthening the program and insuring its full usefulness to the country.

In preparation the association requested State hospital organizations to conduct meetings and arrange for discussions which would provide a documentation as to the feelings of hospitals about medicare and recommendations which are felt to be essential to the best possible operation of the program.

Detailed reports were received from 41 States. Also, the association has been devoting a great amount of effort to assist hospitals and to work out various problems as they arose.

We have maintained continued close working relationships with a variety of staff groups within the Social Security Administration and with the Blue Cross Association, which is serving as the major intermediary in the administration of the program.

Also, the officers of our association have had periodic meetings with representatives of Secretary Gardner. In the overall, we find the problems break down into two groups—those which may be subject to administrative change and those which we believe will require legislative change. The latter group will be discussed by other members of our group here following me.

In respect to the administration of medicare, we believe the program has gotten off to an amazingly good start when one considers all that is involved to undertake a program of the magnitude of the medicare law.

It was to be expected that numerous problems of administration would arise and some of which could only be settled on the basis of experience. The intermediaries have had continuing discussions with the Social Security Administration in respect to various matters, and we have had discussions between key personnel representing Blue Cross plans, the American Hospital Association and the Social Security Administration and jointly considered various matters which needed correction as we all gained experience with the program.

INFORMATION PROGRAMS

On the basis of the detailed study undertaken within the States together with our own information, we find that there is a great need for a continuing and intensified information program to familiarize the beneficiaries with the medicare program.

There is a great lack of understanding in respect to the exact benefits available, and particularly in respect to the deductibles and coinsurance features of the program. Hospitals find their position of continually attempting to explain and justify what the Government did in this respect exceedingly distasteful. There is widespread misunderstanding as to the particular role of the extended care facility.

We strongly support the provisions in the law pertaining to extended care and the vision which the Congress had in providing for such an extension of acute hospital care.

However, the difference between extended care and nursing home care is widely misunderstood. We all need to carry on a continuing program of public education, but we believe a very great deal more needs to be done by the Federal Government.

HOME CARE PROGRAMS

We find that procedures with regard to eligibility and participation in home health care programs are misunderstood and appear to be unduly complicated. The different circumstances pertaining to eligibility for home health visits as part A and part B are confusing.

NONCOVERED INDIVIDUALS

There has been a considerable amount of concern expressed about medicare coverage for individuals who reach the age of 65 after Janu-

ary 1, 1968, and who do not have protection either under the railroad retirement or the social security benefits.

We understand that approximately 100,000 individuals will fall in this category each year after 1968. Perhaps some means should be found for bringing them under the program.

There is continuing difficulty with the present definition of a "spell of illness" and suggestions are made that it would be helpful if a spell of illness was defined in relationship to a diagnosis rather than a span of time.

CERTIFICATION AND RECERTIFICATION

The present requirement considering certification of a patient's admission is, we believe, completely unnecessary. It constitutes one of the most troublesome problems in the admission and handling of patients and its results in extensive delays in billing following a patient's discharge.

The hospital finds it is in the middle of the problem as many physicians are adamant against having their word questioned as to the admission of the patient.

We believe the customary practices which follow from the request of a member of the medical staff for the admission of a patient to a hospital should meet any justifiable concern the Government may have.

The fact of the patient's admission, the fact of a physician ordering treatment and the fact of a patient being discharged by a physician does, we believe, provide fully for the reasonable concern the Government may have as to the necessity of payment for care. The present departure from the accepted practice for all other patients in the hospital is we strongly feel unnecessary and harmful.

We urge, therefore, that the requirement for a signature of the physician certifying admission of medicare patients be eliminated.

The other problem in this area deals with recertification. There is a good deal of criticism of the recertification procedure. A single specified date for recertification of a patient combined with the utilization review process should constitute a reasonable protection to the government and should enhance the work of the utilization review committee.

UTILIZATION REVIEW

We fully support the utilization review process. To function effectively for medicare patients utilization must apply to all other patients in the hospitals and as a consequence everyone will benefit.

However, it must be clear that no hard and fast rules can yet be established and it is desirable that the utilization review process be permitted to develop along different lines, as it is today, in keeping with broad general principles and desired goals.

Numerous suggestions are coming from the field as to improvements in the process and wide differences of opinion are being expressed in respect to particular points. We feel it is very wise to encourage and stimulate the role of the administrative intermediary in the surveillance of the utilization review process.

LEGAL RESPONSIBILITY OF PHYSICIAN

Though independent opinions have been expressed by several sources that an individual physician would not incur problems of legal liability by serving on utilization review committees, we feel that it is time that the Federal Government itself expressed an opinion on this point. Perhaps an official legal opinion from the Department of Health, Education, and Welfare, which is given to all institutions and physicians participating in the program would provide the assurance which is needed.

MAJOR PROBLEMS FOR HOSPITALS

The major problems encountered throughout the entire hospital field pertain to hospital-physician relationships, outpatient benefits, the use of deductibles and coinsurance and a reimbursement formula that results in inadequate payment for hospital services.

I cannot emphasize too strongly the widespread concerns which exist in respect to these matters which will be discussed in detail by representatives of the association to follow me.

The hospitals of the country believe the necessary changes must be made if the medicare program is to develop and serve its purpose.

We had many discussions with representatives of the Secretary of the Department of Health, Education, and Welfare in respect to what would go into the reimbursement formula.

At the time medicare went into effect we pointed out in discussions with Secretary Gardner the serious reservations we had as to the adequacy of reimbursement. The Secretary assured us and confirmed in a following letter that as experience developed he would be glad to consider fully any inadequacy in the reimbursement as facts indicated the need.

With this promise the American Hospital Association proceeded to urge hospitals to participate in the program and decided not to pursue the matter through legislative channels. I can assure you that without such action by this association a great many hospitals would not have been willing to become participating hospitals.

However, the Congress changed this whole picture when it decided to add an additional payment of 7½ percent of net worth or equity as defined in the regulations to the reimbursement of proprietary institutions and withheld any commensurate recognition of the needs of the nonprofit institutions.

I am pleased that Mr. Ray Eppert, who will follow me, is going to discuss fully the real significance of this decision by Congress as it appears to the hospital field.

Though we do not plan to comment upon the proposal in H.R. 5710 to extend health insurance protection to disabled beneficiaries, we do note that the cost of such an addition is \$225 million in the first year and we note the statement that this addition can be made from the existing tax base.

We also note other changes which are going to cost more money. It does appear to us that the Federal Government has an obligation to provide fully for the financial needs of the existing program before it undertakes additional obligations.

CAPITAL NEEDS OF HEALTH FACILITIES

Though Mr. Eppert and Mr. Mueller, who are to follow me, will discuss capital needs in considerable detail. I do wish at this point to include a statement which the board of trustees of the association approved as a guiding policy:

The orderly development of a strong health service system requires clear recognition of the capital needs of health facilities, as follows:

a. To meet existing capital commitments, funds are absolutely essential for: amortization of existing debt and provision of depreciation at replacement value, for facilities currently in place and in use.

b. To require funding of depreciation by each institution when all current fiscal obligations and needs of health service institutions for operating expense, debt service and amortization have been met, such funded depreciation to be used only for replacement of essential equipment and facilities and keeping the equipment and facilities effective, efficient and compatible with medical and technological progress but not for expansion or major reconstruction unless in accord with an approved areawide plan.

c. To recognize that all expansion, major reconstruction, major modernization of buildings and change of use however financed and all new capital expenditures whether financed from gifts, borrowing, government grants or any other source must be subject to approval by the appropriate local planning agency.

This requirement to be equally applicable to all health service institutions whether voluntary nonprofit, church-sponsored, proprietary or government owned.

TITLE 19

I would now like to comment briefly on title 19 of the law. We believe that within the span of a few years the total number of persons receiving health services under title 19 may well be twice the number covered under title 18.

Therefore, this program is of very great importance to hospitals. We feel the Congress made some very important changes in respect to the provisions of health services to needy persons, and we supported them. We hope that the basic improvements made by the Congress will not be removed in the amendments now being proposed for the program.

In our long discussions with the Social Security Administration in respect to the basis of reimbursement for title 18 we continually recommended a system of average per diem costs. The Social Security Administration argued against such an approach and defended their position on the basis of what they claimed the Congress intended.

They, therefore, instituted a system of reimbursement called the RCC method which allocates cost on the basis of relating costs and charges. This system is, in fact, a great departure from the widely accepted methods of reimbursement in effect in the hospital field. The hospital field is moving as rapidly as it can to the use of more complete cost accounting methods.

We note that the Congress intended that medicare would pay the reasonable cost of services provided. We believe it is yet to be demonstrated that the RCC method is a satisfactory basis for the allocation of costs in hospitals throughout the country.

On numerous occasions we pointed out to the representatives of Secretary Gardner that the government was embarking on a course which could only be justified if all other purchasers of care moved to the same system.

Specifically, we pointed out that the philosophy that they were insisting upon for medicare, would by force of circumstances require hospitals to be reimbursed on the same basis for all patients under title 19.

We pointed out that this would mean that each of the various patient groups for which care is provided under title 19 would have to be handled separately and reimbursement should be on the basis of the cost of each group.

For example, hospitals would have to treat children as a group, and in fact, they could well justify separating children into medical care and surgical care so that for once the very high costs incurred by a large number of children for heart surgery and other types of major surgery will be paid.

Certainly the hospitals would have to insist on treating all obstetrical patients as a group. This means full payment for what are short-term patients at high costs per patient day. Hospitals cannot tolerate government treating all patients under title 19 as one group and expecting to obtain the benefit of averaging costs over the whole group.

At the present time the law stipulates that hospitals must be paid their "reasonable costs" under title 19. The law does not include extended care facilities or skilled nursing homes. We believe it would be desirable to amend the law so that extended care facilities and skilled nursing homes were also insured a reasonable cost as a basis for payment for care.

HEALTH INSURANCE PAYMENTS TO FEDERAL FACILITIES

We note that section 126 would amend the law so as to permit payment to federal facilities for care provided to medicare beneficiaries. We believe this is an undesirable proposal. We feel it is unwise to open up Federal hospital facilities to the care of civilians.

For example, we believe that medicare beneficiaries have no business being in a veterans' facility for non-service-connected conditions except on the basis of documented financial need.

The amendment suggested would make it possible and would, in fact, encourage veterans to seek care in such facilities. We would urge that this amendment be rejected and that payment for care in Federal facilities be restricted to emergency conditions as it is under the existing law.

As the president of the American Hospital Association and on behalf of the hospitals of the country, I wish to express our appreciation for the opportunity afforded us for a full discussion of the concerns of hospitals in respect to the medicare program.

I wish to reiterate our unqualified intention of doing everything we can to make the medicare program of greatest possible benefit to the intended beneficiaries of the program. And I would like now, sir, to yield to Mr. Ray Eppert.

Mr. KARSTEN (presiding). Mr. Ray Eppert.

STATEMENT OF RAY R. EPPERT, AMERICAN HOSPITAL ASSOCIATION

Mr. EPPERT. Mr. Chairman, my name is Ray Eppert. Until my retirement a few weeks ago, I was chairman of the board of The Burroughs Corporation. I appear here today in behalf of the American

Hospital Association and in my capacity as chairman of the board of trustees of Harper Hospital, Detroit, Mich. I am also president of the Detroit Medical Center Development Corp.—a nonprofit organization made up of trustees representing five hospitals and a state university medical school. We are undertaking at the present time a major cooperative venture between government and the private sector to the end that the medical school can double its size in the next five years.

For 18 years I have enjoyed the privilege of serving as a member of the board of trustees of Harper Hospital, a 711-bed hospital which as a private, nonprofit corporation has been serving Detroit and Michigan for 104 years.

My efforts, like those of all the Harper trustees, and may I add, the trustees of all other nonprofit hospitals, are provided as a community service, without any financial compensation from the hospital. I should add that the trustees are legally responsible for the fiscal integrity of the institution and often are personally involved in gifts to the hospital.

Our efforts as trustees are directed toward providing for patients the best possible hospital care, the highest possible standards of medical care, and the latest and most complete health facilities.

Obviously, we are deeply interested in the medicare program. As I see it, the start of medicare was like the release you might say of a new product in the market; and today we are having a postproduct release discussion to find out how good the product is, the market acceptance to date, and to discuss frankly any product weaknesses and added features which will insure greater success.

Harper Hospital, I believe, may be likened to many thousands of similar institutions which blanket the Nation. Together they make up a large part of the truly unique health-care system we have developed in our country under which individual and community responsibility is directed toward meeting the needs of the people and the task is not left entirely to Government.

I am quite certain that there is no question in the minds of any member of this committee or of the Congress that hospital care must be available and the hospital needs of the people must be provided for.

However, I also believe that it is in the best interest of the country that such a task not be left solely to Government but rather that we continue to work for the largest possible amount of voluntary effort and capital and that the role of Government be one of support.

I strongly urge that this future be planned so that a healthy and vital partnership be developed between the voluntary sector and the public sector in health affairs.

The concerns of the Federal Government in hospital affairs have increased materially. The medicare law is the present dominant example of the Government's growing concern. I have really just one message that I would like to bring to the committee today and that is to express the fervent hope that medicare will be allowed to develop so that the private community hospitals, such as Harper Hospital, are enabled to change and grow and remain a vital force in the field of health care. To fail to do so would be a great disservice to the country.

As I see it, medicare and titles 18 and 19 of the law can make or break the private, nonprofit community hospital.

In the hearings before the Congress, which preceded the enactment of the present law, there seemed to be a strong desire on the part of this important committee to so fashion the law that to maximize opportunities for Government support would insure hospitals the bright future which is vital to the country's health program.

I realize that translating broad congressional intent into working, administrative procedures is a difficult task and I do not underestimate the great responsibility placed upon the Secretary of Health, Education, and Welfare and the efforts which have been made to administer the law in keeping with the congressional mandate.

The community general hospital is a uniquely American institution. It is part and parcel of the great free enterprise system of our country, and yet it is rather totally unlike other enterprises.

If I may, I would like to dwell a few minutes upon the example I know best—Harper Hospital.

Harper Hospital was established in 1863 as a private corporation, and it is operated as a nonprofit organization insofar as no profit inures to the benefit of any individual. Its purpose is to meet community needs, the needs of those sick persons and I will categorize them, who are able to pay fully for their care, those who can pay for their care in part, and those who cannot pay for their care at all. The total book value of the Harper Hospital plant is \$18 million. In a typical year we provide 221,000 days of bed care to the 22,500 inpatients admitted, 2,500 babies are born and their mothers cared for. We provide 51,000 visits on an average to indigent patients in our outpatient department.

Harper Hospital contributes in a major way to the education of health personnel. We conduct a program of medical education for 105 interns and resident physicians. One of the three approved internships in the State of Michigan for dietitians is in Harper. We operate a diploma school of nursing for 240 students. We provide a program in the field of medical technology for from 15 to 30 students a year. We provide a program for students in hospital administration; such students are working for their masters degree in one of the universities providing such advanced degree programs.

We have a research budget which averages about \$200,000 a year and is financed from various sources. It was in Harper, incidentally, that the first mechanical heart was developed which made possible open heart surgery. This original equipment is now in the Smithsonian. All of these hospital activities, I feel, are a contribution to the community and to the country.

The hospital is operated with a broad social purpose, and though the hospital is fully businesslike in its administration, with a highly educated and skilled administrative staff, sometimes decisions must be made to do things which may appear unbusinesslike in the usual sense of the expression.

I know of no other business which provides its services or products to customers who it knows may not be able to pay. This is a distinguishing feature of the voluntary, nonprofit hospital system which cannot be ignored.

In my business career, I am unfamiliar with any organization that establishes a major new service or purchases expensive new equipment

except on the assumption that costs will be recovered and that a profit will probably result.

Yet as I sit as a trustee of Harper Hospital I must make decisions that are not supportable by what is normally considered to be good business practice in profit-sharing organizations. It is at this point that economics and humanics merge.

In this regard, I would emphasize what I feel is an extremely important aspect of hospital operation and one which is widely misunderstood by persons both in and out of government. The financial problem—the increased cost problem—of hospitals could be easily settled and eliminated, you might say, by an empirical decision of the trustees. The hospital could close beds and cease operating various functions. It could cease giving any care to anyone that can't pay for the care.

This could be done quickly. It could also set upon a program of reduced quality of care. The financial problem of hospitals arises not from taking such action, but rather because it is not taken. Their problems arise from meeting public needs and that will not change because of historical trustee commitment and dedication.

Quality care in hospitals cannot be likened to other services and commodities you and I purchase and which by common consent need not always be the very best. There is yet to be a patient admitted to Harper Hospital in 104 years who states a preference for less than the very highest quality of care and all that we have to offer.

Nor have we ever consciously offered any such choice, or ever will voluntarily. However, demanding the highest quality in this country, with all it entails, suggests obligations. The best is expensive. It is pleasing to see the Federal Government supporting high standards of care, but neither the Government nor the public can have it both ways. They must be prepared to pay the justifiable price for their commendable choice.

I do not think I have to tell you that I am an advocate of the profit system. I have spent my entire life working within that system, and believe I understand and appreciate the broad benefits this country and all of us as individuals have derived from such profit motivation.

Yet I seriously doubt that it is possible or wise to depend, in the health field, upon hospitals developed primarily as private profit organizations. These proprietary profit institutions serve their communities well and provide an essential service, but it would be a mistake to leave the future of hospital care entirely in the hands of such organizations. The hospitals which undertake the teaching of physicians, nurses, dietitians, medical record librarians, technicians, and other paramedical personnel are notably operated as nonprofit organizations.

It is in these hospitals that the research is done and the major advances in medical care take place. It is unlikely that the community services provided in the uneconomic areas of care, such as emergency and outpatient care and in the obstetrical department, and the like would ever have developed as they have in this country if they had been left to the motivation of profitmaking hospitals.

The public benefits fundamentally by the services of the voluntary governing board of the nonprofit community hospital. It is inde-

pendent of political interference; it is free to use its best judgment in the selection of the medical staff and to establish the framework of rules and regulations by which the staff then controls itself.

The resulting process of physicians looking over the shoulder of one another results in the kind of quality control that is not equalled, I believe, in other parts of the world.

No one claims it is perfect, but nowhere outside the area of responsibility of the nonprofit hospital, and this I want to underscore, does the public receive equal protection in the provision of health services.

In the aggregate, hospitals are said to compose the third or fourth largest industry in America. Hospitals are owned and operated by nearly all levels of government as well as by private individuals and corporations for profit and by nonprofit corporations and religious bodies.

Specifically, hospitals are operated by the Federal Government, by State and local governments, by proprietary organizations and by nonprofit associations.

Therefore, quite apart from being an essential public service, they are a major economic force in the country. Their plant assets total \$20 billion. Their annual purchases amount to about \$4.5 billion. They employ 1,800,000 full-time workers and they provide a payroll of \$8.5 billion annually.

In a great many communities the hospital is the largest employer. The services it performs are absolutely necessary to the healthy economy of the overall community. Sick employees cannot work and sick people are not really very good customers for any business, and the quicker they are returned to good health, and to normal pursuits, the better off business is and the economy is as a whole.

As a businessman, therefore, I strongly endorse the premise that hospitals must be assured of a healthy future life and development.

As the Federal Government moves to control the payment of hospital care for millions of people, we must be mindful of the enormous values of the private, nonprofit community hospitals spread across the Nation. To dry up the economic stability and remove the community incentives for such institutions for the sake of apparent short-term financial gains to the Government would be a tragic error in national policy.

Mr. Chairman and members of the committee, I have great fear that a continuation of the present philosophy in respect to reimbursement for hospital care will sap the strength and dissipate the vitality of our vital nonprofit community hospital system.

Let me be specific, at Harper Hospital we are planning the development of our part of a major new medical center. The hospital part of the project will cost \$32 million. Our board of trustees has taken it upon themselves to raise \$16 million. To do this we shall have to receive substantial contributions from trustees, various individuals, foundations and business corporations. Such persons really may be interested in supporting a worthy community project, but only if they have the assurance that the gift they are making is in perpetuity.

This assurance cannot be given if we must depend upon a bare subsistence reimbursement from the Government for services to a group that can well comprise half of all our patients in future years.

If other major financiers of hospital care are encouraged to follow the Government's lead and say to us in raising funds or capital, "Go to Washington, not to us," we will be left with nowhere to turn for the additional growth capital we must have. I ask you, how are we going to sell voluntary support under such circumstances?

Private voluntary hospital trustees know that we need adequate financing in order to maintain our hospital facilities and to continue the growth and development of health services required for our country.

Traditionally we have been called upon to seek a large portion of the necessary funds from the community; and in a growing number of cases, our hospitals have had to borrow in order to replace and expand services required by the community. These community and lender sources have to be augmented by funds generated from revenue.

I believe it is obvious that the Congress did not have the opportunity to consider the large number of hospitals that are heavily in debt because their major plant development was with borrowed money. I know of no industry that can long stay away from bankruptcy without generating sufficient funds from revenue to assist in its capital needs. Hospitals are no exception.

Reimbursement from all sources must contribute to these financial needs. The reimbursement from Public Law 89-97 must be corrected to recognize replacement cost, the need for additional revenue for growth and development, and the need for amortization of debt in those hospitals forced to borrow the necessary capital funds.

As trustees we are committed to maintain the facilities entrusted to our care. Replacement cost is the only means of recognizing the increasing price level of facilities which must be replaced and I believe that the economy is committed to a gradually increasing price level.

If we continue to be reimbursed on the basis of historical cost depreciation as contained in the present medicare formula, we trustees will be faced with a steadily deteriorating ability to maintain our facilities.

As trustees we are committed to the growth and development of services necessary to provide the care our community requires. Reimbursement must provide an integral part of the necessary expansion funds in hospitals, as it does in other industries.

Some growth and development must come from the institutions operating income in order to attract community funds. The hospital cannot continually seek special funds for capital needs and maintain its adaptability to the requirements of the community.

Lenders cannot be expected to commit funds to hospitals which cannot generate sufficient income over and above raw costs to contribute to capital needs and to assist in amortizing debt. Funds generated from reimbursement must include amounts to aid in amortization of debt and the support of growth and development programs of the hospital. The 2 percent now allowed nonprofit hospitals in the reimbursement formula is not sufficient to meet these needs.

A few moments ago I mentioned the Detroit Medical Center development project. On the boards of trustees interested in the project there are more than 100 leaders in our community who are occupied in their normal business and professional responsibilities but are still anxious to give great amounts of time and effort to this community project.

Any one of these men could give a worthy dissertation on free enterprise and the private business system. Isn't it significant, highly significant, that they are working for nonprofit hospitals not proprietary institutions?

I believe you can take any list of businesses and corporations in our country and you will find that their leadership is serving on nonprofit hospital boards. Just what is it that a businessman dedicated to the profit motive sees in these nonprofit hospitals?

Well, he sees the free enterprise system as something much broader than producing individual and corporate profits. He believes it also means freedom to operate, freedom of incentive, freedom for change, freedom to improve the quality of a product. In the operation of a nonprofit hospital he finds these same freedoms.

These hospitals provide more than the basic essential services. They offer their communities high quality health care, and they do this not because they have to but because they want to. Business leaders want the hospitals to continue to have this same freedom of action—not for the sake of profits—but so they can always continue to innovate and improve and keep their services at a high level of quality and efficiency.

Now to get down to some figures. The total assets of all short-term general hospitals in the country is \$16.4 billion. This group consists of the hospitals operated by voluntary nonprofit organizations, proprietary organizations, and those operated by State and local governments. Of this total the assets of the private nonprofit community hospitals amount to \$12.5 billion. The total assets of all private for profit proprietary hospitals is only about \$400 million.

Approximately 75 percent of all non-Federal short-term general hospital plant assets are in the private nonprofit hospital sector.

Recently the Congress decided to increase the reimbursement of profitmaking hospital institutions by about 7½ percent but it did nothing proportionately for the nonprofit hospital. It is difficult to understand that the Congress decided to make this investment for the future only in proprietary institutions.

If it were to make a similar investment in nonprofit hospitals, the 7½ percent would go to perpetuate the enormous private investment in hospitals which now exists to the benefit of the Government as well as the people. It would not be subject of course to any payout in the form of ownership withdrawals, dividends to shareholders, and so forth. It could only go to improve. The money given to such institutions would be working all the while, as I said, for better plants and for better care. I think it would be prudent and strong economic policy for the Government.

Now, I would like to move for the moment to the matter of depreciation funding. We subscribe to the necessity of sensible planning for new hospital facilities and strongly support voluntary areawide planning agencies. There is such an organization in Detroit and operating efficiently.

We also wish to call to your attention the rapid development of such agencies in the United States in recent years. Now numbering over 80, these agencies are bringing conscientious appraisal and effective coordination to planning of health care facilities and health services.

We also recognize the need for coordinated Statewide planning. The State level health services and facilities coordinating groups should

blend and meld both private and governmental representation in its governing body.

However, we believe that planning agencies should influence capital expenditures for the creation of new facilities or the expansion of existing facilities only, and not expenditures for replacement of equipment and services in existing hospitals.

These expenditures, we believe, come within the normal responsibility of operation. The proposal for handling depreciation funds as it appears in H.R. 5710 provides not only control of capital expenditures by a planning agency, but also that approval must be obtained from such an agency for the expenditure of depreciation funds for operating purposes.

This fully removes the authority of the individual governing board of trustees and I believe interferes with the legal responsibility of the board of trustees for the operation of the hospital.

Further, the proposal indicates that the Federal Government can bring sanctions against a hospital in respect to the expenditure of depreciation funds received from other sources and for which the Government has no responsibility.

This proposal is obviously unacceptable. If the Government believes it must require funding of depreciation monies paid to a hospital under title 18 and 19 of the law, and if it requires complete fund accounting for such funds, this might will be defensible if the government was actually paying for the replacement of facilities at some future date and at some future price.

However, it is not doing so and as matters stand depreciation funds which the Government is paying to a hospital are being paid on an existing facility. The reason they are being paid is because depreciation is a legitimate item in reasonable costs. Just what the basis is for the Government deciding it should control this element of reasonable costs is not quite clear to me.

Thus, we think the proposal should be limited to the control of depreciation funds used for the construction of new facilities, and the provision of additional beds and services.

Specifically, hospitals should be permitted to spend depreciation funds for replacement of equipment and for expenditures which are in the accounting sense within the area of normal operations. Use of any and all depreciation funds should be traceable through use of proper accounting procedures. Control by a planning agency over such items should be eliminated.

The action of the Board of Trustees of the American Hospital Association regarding depreciation as covered in Mr. Cartmill's statement provides sound operating policy in this matter. This statement recognizes that many hospitals have a substantial existing capital debt which cannot be amortized entirely by use of depreciation funds.

In fact, the necessity of using depreciation funds for amortization of substantial capital indebtedness precludes in many cases funding of depreciation for preservation of the existing plant. We believe that the concept of depreciation as an allowable cost is proper; but until depreciation is paid at replacement values and until a proper level of total reimbursement is achieved to assist in paying off existing capital indebtedness, the proposal to control rigidly the use of depreciation

funds is impossible and impractical and will serve only to downgrade the ability of voluntary nonprofit hospitals to maintain existing facilities let alone meet the needs for improvement, equipment replacement, and maintaining high-quality facilities to provide high-quality services.

Stated differently, such a policy if continued would place voluntary institutions in a program of gradual liquidation.

There are more than 30,000 individuals—this is an understatement—serving on the governing board of hospitals. They undoubtedly represent a cross section of men and women in business and industry in small town and big city, who believe sincerely in the community good of the nonprofit hospital, and are willing to give their time and energies to further its purpose.

I am certain that any one of these thousands of trustees would have spoken to you in the same way I have today. In conclusion, it would seem apparent, I believe, to any observer that unless the hospitals which must provide the care are enabled not only to survive, but to grow and develop, the medicare program will certainly suffer as well as the hospitals.

I will state it very frankly, brutally frank. The success of medicare in our opinion, in the foreseeable future, is predicated almost entirely on the continued healthy and dynamic progress of the private voluntary hospital system because that system represents 75 percent of the assets employed in our total non-Federal hospital facilities. Without it there could be no program.

Thank you very much, Mr. Chairman, for the opportunity to present these thoughts to you, and I hope they will be helpful in carrying out your committee's great responsibility.

Now, Mr. William Mueller.

The CHAIRMAN. Thank you, Mr. Eppert. Mr. Mueller.

STATEMENT OF WILLIAM J. MUELLER, AMERICAN HOSPITAL ASSOCIATION

Mr. MUELLER. Mr. Chairman, I am William J. Mueller. I am a partner in the firm of Arthur Andersen & Co. I appear here today in behalf of the American Hospital Association. With me is John R. Stagl, director of Passavant Hospital, who will join me in the discussion of the matters I present.

My testimony will be directed toward those financial, recordkeeping, and administrative problems which I have observed with respect to the involvement of the hospitals with the medicare program. The matters which I will cover can be categorized as follows:

- (1) Problems relating to the definition of "reasonable cost."
- (2) Problems relating to the adequacy of "reasonable cost."
- (3) Administrative problems.

In preamble, I would like to make one general point: While the impact on hospitals of title 18 of Public Law 89-97 has been great (the March 16, 1967, issue of the Journal of the American Hospital Association will, for example, contain the results of the monthly hospital indicators. These will show that the percent of patient days for patients aged 65 and over increased from 28.2 percent in July 1966 to 32 per-

cent in December 1966) the implications of this legislation on hospitals and on their financial management is greater than even these high percentages would indicate.

With the gradual implementation of title 19 and with the almost inevitable conversion of other third-party payment plans to reimbursement formulas approximating those contained in the medicare regulations, it is not unreasonable to forecast that within a short period of time, the vast majority of all hospital patients will have their hospitalization paid for on the basis of the rules and formulas which are being evolved today in connection with the medicare program.

Accordingly, I believe that the Congress of the United States has a grave responsibility to develop a reimbursement plan which not only meets the needs of this Federal program, but rather, one which can serve as a model for all third-party payors.

PROBLEMS IN CONNECTION WITH THE DEFINITION OF "REASONABLE COST"

I would now like to discuss some of those problems which arise in connection with the definition of "reasonable cost."

The problems of definition which I will outline for you will be limited to those problems which would appear to be correctable only through legislative revision. Many other questions with respect to the definition of reasonable cost have been raised, are being raised, and will be raised in the future.

However, most of these are regulatory in nature and will, I hope in the near future, be clarified by the issuance to providers by the Social Security Administration of appropriate regulations.

To date, there has been a serious absence of such documentary material in the reimbursement area. The result of this deficiency has been much uncertainty in the hospital field but will, I hope, soon be corrected through normal administrative channels.

Most of the significant problems of definition which have become apparent to date appear to be the result of a relatively narrow interpretation of the phrase "reasonable cost." The specific problems noted are as follows:

Special-purpose donations

Principle 1-6, "Grants, Gifts, and Income from Endowments" (Reg. Sec. 405.423) states in part that "grants, gifts, or endowment income designated by a donor for paying specific operating costs should be deducted from the particular operating cost or group of costs."

While I do not of my own knowledge know the full line of reasoning which caused the Social Security Administration to draft this portion of the regulations in this manner, I can only presume that it was so drafted in response to the legislative request that reimbursement be limited to reasonable cost.

I believe that the handling of these so-called specific-purpose donations in this manner is inequitable to the hospital as well as to the original donors.

In considering this issue, separate attention should be given to special-purpose donations based on the time at which they were originally established at the hospitals. These would fall into two basic groups:

(1) those donations which were made prior to the enactment of this legislation, and (2) those donations made subsequent to its enactment.

In the latter case, I predict that there will be a precipitous decline in the number of current donations made to offset specific operating expenses. Certainly any donors who wish to make a donation of this nature will, and should, be advised that their donation will, to the extent of medicare participation, be turned over to the U.S. Government.

I feel quite certain that it is not the intention of the typical donor of funds to subsidize the U.S. Government hospital insurance programs and, as a consequence, the donors will either not make the donation at all or will make it to the hospital for general or undesigned purposes.

I would also prognosticate that in some cases there will be unwritten understandings between donors and hospitals with respect to the way their funds will be used without, however, any legal restrictions being placed on them. It is my contention that any legislation which promotes (a) the discouragement of contributions to hospitals, or (b) any subterfuge in connection with such donations, is basically unsound and not in the public interest.

In addition, the administrative consideration which must be given to this type of situation is not inconsiderable and as such is costly to the medicare program and to the public generally.

While the problem with respect to current gifts is serious, and I do not wish to understate its importance, I believe that of far more significance is the impact of this program on grants and endowments made before the enactment of Public Law 89-97. These consist of special purpose donations which had not been expended as of June 30, 1966, or endowments which had been given to the hospital by its benefactors many years ago, the income of which is restricted to use in offsetting operating expenses.

It seems obvious that it could never be construed that it was the intent of these long-gone benefactors that their donations be used to finance hospital prepayment programs, be they governmental or private in nature.

I therefore believe quite strongly that to offset these items against reasonable cost acts in effect as taxation without representation.

Consequently, I would certainly recommend that as a minimum, all special purpose donations made before the enactment of this legislation be automatically excluded from its provisions.

In this same connection, a recent medicare communications report, issued by the Blue Cross Plan for Hospital Care of Hospital Service Corporation of Illinois, dated February 20, 1967, states that with respect to current special purpose donations, if the donor specifies that the donated funds not be used for services to medicare beneficiaries, no reduction of allowable costs would be made for these donated funds."

If this communication properly reflects the attitude of the Social Security Administration with respect to the subject, it appears that current donors may exclude medicare beneficiaries from their specific-purpose donations but that donors who made contributions prior to the enactment of this law, many of which are long-since deceased, could not have this same privilege.

2. Cost allocation and apportionment formulas

Section 1861(v) (1) defines reasonable cost and states with respect thereto:

Such regulations shall . . . take into account both direct and indirect costs of providers of services in order that, under the methods of determining costs, the costs with respect to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs.

This seemingly innocuous and in fact sound statement of fiscal principle has inaugurated what is possibly one of the most massive crash cost-accounting programs in the history of this country.

Presumably pursuant to such legislative direction, the Social Security Administration has promulgated a relatively complex set of cost accounting devices which attempt to isolate the "reasonable cost" applicable to covered patients.

These call for (1) the determination of "allowable cost" on a departmental basis, (2) the allocation of the costs of nonpatient service (overhead) departments to patient-service departments (this process is known as cost finding), (3) the apportionment of the costs of such patient service departments between those services rendered to inpatients and those services rendered to the various classes and types of outpatients and finally (4) the apportionment of costs within each of the inpatient and outpatient categories between health-insurance covered and all other patients.

Before I outline the problems caused by this process, I wish to state unequivocally that I am not against cost accounting or financial analysis. As a matter of fact, inasmuch as I derive my personal livelihood from it, I am very much for such analysis work.

What I am against is the use of this type of rigid formulation as a basis for determining the primary revenue structure of the hospital industry.

I will also not attempt to dwell on the purely administrative problems which this type of reimbursement method imposes on the hospitals, including such matters as the upgrading of accounting expertise, the time necessary to prepare the cost-accounting data, which is, I assure you, not in any respect inconsiderable, nor the inevitable costs involved in negotiating annual settlements, such latter costs to be measured not only in terms of cost to the government of review and audit, but also cost to the hospital in terms of the administrative time which must be devoted to the process.

Rather, I would like to limit my comments in this regard to the very basic stipulation that this whole series of complex cost manipulations does not accomplish the result demanded by section 1867(v) (1) which I have previously quoted.

In the first instance, while the basic specifications for the cost-accounting function, the process of allocating overheads to patient-service departments, is reasonably sound, the actual apportionment of the resultant costs between covered and noncovered patients is made primarily on the basis of the hospitals' internal rate structure, that is, the amount it sets up as charges made to its patients.

The result of this process is that the Government may pay more or less than cost applicable to Government patients, depending upon the

composition of each individual hospital's rate structure. If the hospital rate structure is calculated in such a way that each of the individual charges are related to cost, then a somewhat more equitable answer will result.

The practical facts of the matter are, however, that, as of the present time, very few rate structures are constructed in this manner and even in those cases where a general relationship to cost exists, rates are typically adjusted on a judgment basis to discount such policy considerations as standby facilities, public-service facilities, experimental procedures, high-cost procedures, and so forth.

In addition, approximately 50 percent of the hospital's cost is billed to patients in the form of a daily charge for routine services. This daily service charge is intended to reimburse the hospital for such costs as patient rooms, meals, nursing service, and so forth.

These charges are universally established on the basis of the type of accommodation occupied by the patient and in no instance that I know of at least, do these charges reflect the cost of the specific array of services rendered to each individual patient.

In other words, if two patients occupy a semiprivate room, one may receive as much as five times as much service as his roommate; however, the hospital routine service charges to each of them will be identical, because they both occupy the same type of accommodation.

Studies indicate the cost of routine services is typically higher for the medicare patient because of his age and the typical types of infirmities brought about by age. Therefore, the application of cost allocation procedures based on rates would not properly reflect the cost of services rendered to the medicare patient.

Cost accounting systems designed to cope with this problem are presently in a study phase, but I would venture to say that it will be many years before they are both perfected and made operational in hospitals, and it will probably be many years beyond this before the average hospital will be able to incorporate such changes in its rate structure in an equitable manner.

In summary, I would conclude that while the cost apportionment methodology specified by the Social Security Administration is obviously prepared to be responsive to the legislative requirements contained in section 1861 of the law, I would say that in many—if not most—situations, the responsiveness is not adequate.

I, at this point, want to make it very clear that I am not critical of the attempt made by the Social Security Administration to draft regulations which attempt to meet the legislative intent. I, frankly, do not think that it is possible to accomplish this intent.

Accordingly, it is my belief that until such time as accounting and analysis techniques are developed to the point where it is not necessary to rely on rates to make these basic apportionments, that the legislation should be amended to permit reimbursement on the basis of average cost, as well as any more sophisticated method as might be developed on a sound basis on an individual hospital-by-hospital basis.

3. Return on investment

Principal 1-12: "Return on Equity Capital of Proprietary Providers (Reg. Sec. 405-429)" provides that a return will be allowed on the equity capital invested in proprietary institutions. Equity is defined

to exclude long-term indebtedness. This definition fails to recognize several very important economic factors and could in operation prove to be extremely inequitable to the owners of proprietary institutions.

In the case of an owner who maintains a low equity position, either due to the incurrence of losses in connection with the startup of a new facility, or that he was able to borrow from outside sources an extraordinarily high percentage of his total capital or otherwise, this rule would practically eliminate the possibility of his earning any return on medicare patients.

Furthermore, if the interest he pays on his long-term debt is less than the rate of return allowed under the law, then, everything else being equal, the Government would be paying less to hospitalize a patient in an institution with an extraordinarily high debt ratio than they would in an institution that was debt free.

It would seem to me only proper that the Government in contracting with proprietary institutions, not concern itself with the method that these institutions use to obtain their financing.

Rather, I would recommend that interest be disallowed completely as an element of reasonable cost, but that a return be allowed these operators on the gross amount of assets employed in their business. In this way, charges to patients (that is, to the Government) would be identical with respect to identical facilities, and the individual operator would be left to his own discretion as to whether he wanted to operate a conservatively financed institution with no debt or a highly levered institution with a high debt-equity ratio.

It would, of course, also permit the operator who has no equity to build one, and this would, I believe, be a desirable objective.

PROBLEMS RELATING TO THE ADEQUACY OF REASONABLE COST

The next section of my testimony has to do with problems relating to the adequacy of reasonable cost. The issue as to whether or not reimbursement based on cost, or cost plus 2 percent, adequately meets the hospital's financial needs cannot be stated categorically as financial needs will vary hospital by hospital. In most instances, however, cost will certainly be inadequate.

How much a hospital may need over and above its basic operating costs to meet its financial requirements, is a difficult question to answer on a generalized basis. Each hospital is different, each has its own needs and requirements.

Also, there are many definitions of cost and many ways in which cost can be assigned in terminating the cost applicable to the care of patients. Without overcomplicating the issue, however, I would like to discuss the two broad elements which must be considered in connection with any consideration of the financial needs of hospitals.

These are that first, a hospital must always recover on a current basis the amounts of its day-to-day expenses of operation which are often referred to as "out-of-pocket costs."

Secondly, a hospital must provide itself with adequate resources to meet its needs for permanent capital.

While a cursory examination of medicare legislation would seem to imply that the phrase "reasonable cost" would encompass all day-to-

day "out-of-pocket costs," a closer examination reveals that—in at least one important respect—they do not.

The area in which at least the administrative decisions with respect to the definition of reasonable cost are deficient lie in the area of free care rendered to certain categories of noncovered patients. This free care in general relates to two types of patients.

The first of these are the type which are at least presumably able to pay their bills, but for some reason or another, they do not, and become credit losses. The cost of such bad debts or credit losses applicable to nonmedicare patients is not allowed as a cost under the regulations adopted with respect to the medicare program. Any credit losses attributable to medicare patients are reimbursed under the program.

The cost of caring for patients who eventually become credit problems is a cost of operating any hospital whose doors are open to the public. It is as much a cost of maintaining an open institution as the cost of the telephone operator or the nurses or the maintenance men. It is a cost which much be borne on a proportionate basis by the paying patient—be that paying patient sponsored by the United States Government or a commercial insurance company, or be he one who pays his own bills out of his own pocket.

The only alternative to not considering bad debts as an over-all hospital cost to be borne proportionately by all paying patients, is to operate a closed institution which will only admit patients who are sponsored by some third party with unquestioned creditability and turn away all others who might eventually become credit problems.

Such a policy is in conflict with all the moral concepts underlying the hospital industry in this country and, as a matter of fact, in some jurisdictions is probably even illegal.

To attempt to finance this not inconsiderable cost by continuing to increase rates for the relatively small portion of patients not sponsored by a third party is certainly unjust.

In the same line of reasoning, hospitals, as a matter of public policy admit patients whom they realize cannot pay their bills. In many cases, these patients are not qualified for public assistance and the cost of their care must be borne by the hospital.

In many instances, these patients are admitted on an emergency basis and there is absolutely nothing which the hospital can do to control their admittance. This then becomes as much a part of the overall cost structure of the hospital as does the credit loss. It is a cost of maintaining an open institution. The alternatives are not even worth considering.

There is also another line of persuasive reasoning under which the cost of caring for the medically indigent might well be considered as a part of the reasonable cost of caring for the paying patient. This line of reasoning considers the cost of such free care as a cost incurred by the hospital in rendering a service to the community in which it is located.

The principle that charitable contributions represent a part of the cost of doing business of the corporate taxpayer has been recognized by the Internal Revenue Code, which allows corporate taxpayers to make charitable contributions in an amount up to 5 percent of their taxable income.

In addition to the specific statutory allowances, most large corporations appropriate significant noncash reserves to community projects, such as providing corporate executives to serve on the Boards of Trustees of hospitals, participating in fundraising drives, Chamber of Commerce activities, and so forth.

It seems inconceivable to me that the corporate commercial taxpayer is permitted to deduct such costs on his Federal income tax return as a cost of doing business, whereas the hospital is not permitted to include a reasonable amount of the cost of charity as an allowable cost in connection with medicare reimbursement.

In addition to the day-to-day, out-of-pocket expenses, incurred by the hospital, which have just been described, the hospital also has a dire and critical need for ever-expanding amounts of permanent capital. The capital to which I refer is those amounts which are invested in land, buildings, and equipment, as well as those amounts which are required in the form of working capital to finance the day-to-day operations of the institution.

While I will address myself at this point primarily to the needs of the hospital for capital invested in plant and equipment, the same principles apply to its working capital needs.

Because of the apparently inevitable inroads of inflation, the purchasing power of a dollar recovered today in the form of depreciation allowances is not equivalent to the purchasing power of a dollar spent on plant and equipment at any time in the past. Depreciation allowances must, in order to comply with the medicare rules, be computed on the basis of the original cost of the physical assets in use.

Consequently, hospitals are limited through depreciation allowances to the recovery of such original cost, with the result that the purchasing power of capital is becoming eroded. Likewise, as medical technology has become more complex, correspondingly larger investments have been required in hospital plant and equipment to support an equivalent number of patients.

Because depreciation provisions are based on historical asset complements, even if they are adjusted for inflation they will be inadequate to provide for the additional investment required to maintain a technologically up-to-date facility.

Because of the interaction of these two factors of inflation and technological obsolescence on the operations of the hospital, depreciation allowances, and consequently reimbursement based upon such allowances, which are based on historical cost, are almost certain to be inadequate when the hospital faces the problem of replacement of obsolete or wornout facilities at a later date.

In addition, these same factors of inflation and technological change influence significantly the amount of working capital needed to finance current operations.

There is, I am certain, no question in anyone's mind as to the accuracy of these general statements. Very little has been done, however, to quantify them in such a way that their effect—even on a historical basis—can be reasonably measured. Some data is available, however, and I will refer to it at this time.

The Public Health Service of the Department of Health, Education, and Welfare publishes certain statistical data regarding the costs

of constructing and equipping hospitals. In a report covering the years 1948-1965, they report that the average cost per bed for new general hospitals increased from \$11,987 in 1948 to \$29,886 in 1965, or an increase of 149 percent. During this same period, by the way, the Bureau of Labor Statistics Consumer Price Index increased from 83.8 percent to 113.1 percent or an increase of approximately 35 percent.

In order to accumulate funds equivalent to this increase in cost of \$17,889 (\$29,886 less \$11,987), it would have been necessary to provide an additional allowance, over and above depreciation based on original cost, of 6 percent per year over the 17-year period, assuming such additional allowance could have been funded and earned a return of 5 percent per annum.

To convert this additional allowance into a percent of operating cost, it is necessary to assume an average operating cost per patient day over this period. If a \$38-per-day average is assumed, this would result in annual cost per bed of \$13,870 (365 days times \$38).

Based on this amount, it would be necessary to receive an additional allowance equal to approximately 5 percent of operating cost, in order to recover the \$17,899 over the 17-year period, assuming again that such additional allowances could be funded and earn a return of 5 percent per annum.

To the extent that donated capital, received either from the general public or from the U.S. Government in the form of grants in aid of construction, has not been adequate to meet the capital needs of hospitals, many of them have obtained long-term capital financing from outside third parties.

This financing, typically in the form of mortgage loans, has been available but only to those institutions which could show, to the satisfaction of the lender, that they would be able to meet the repayment schedules specified. Each lender must, of course, set his own standards with respect to what would be considered reasonable assurance in this regard.

My personal experience has shown that very few lenders are willing to look strictly to the recovery of depreciation dollars for the repayment of their loans. Most lenders require as a minimum a proven record of the hospital having been able to produce an operating surplus, coupled with a clear statement of intention on the part of its board of trustees, that all efforts will be extended to assure that future operations will be similarly successful.

A condition of current stability and the ability to meet its bills as they mature, that is to say, to have adequate working capital at least after the receipt of the long-term loan is also a frequent consideration.

A tabulation of recent mortgage loans to hospitals is attached to this testimony.

Mr. Chairman, I do not have the attachment to the testimony. It is being typed and I will submit it at a later date if that is satisfactory.

Mr. ULLMAN (presiding). Without objection it will be included in the record.

(The following table was received by the committee:)

Pertinent statistics with respect to recent mortgage loans made to hospitals during 1965-66

State	Amount of loan	Total expenses		Net income	Cash flow	1st year debt service	Cover-age	Gross fixed assets	Net fixed assets	Number of beds	
		Out of pocket	Depreciation							Before new construction	After contemplated new construction
Massachusetts	\$2,000,000.00	\$2,288,186.00	\$140,236.00	\$110,499.00	\$250,735.00	\$167,000.00	\$1.50	\$3,623,285.00	\$1,878,073.00	182	235
Alabama	5,600,000.00	2,934,813.00	102,202.00	355,025.00	457,227.00	415,000.00	1.10	\$3,590,979.00	2,887,174.00	250	500
Illinois	1,750,000.00	2,026,282.00	108,292.00	187,891.00	296,183.00	142,500.00	2.08	4,074,142.00	3,491,342.00	210	285
Oregon	550,000.00	661,233.00	28,926.00	54,370.00	83,296.00	37,500.00	2.22	954,915.00	701,708.00	69	110
Tennessee	5,600,000.00	3,433,833.00	240,011.00	294,648.00	534,659.00	355,000.00	1.51	6,002,662.00	3,905,568.00	267	305
Indiana	4,000,000.00	2,854,288.00	242,958.00	48,642.00	291,600.00	270,000.00	1.08	5,235,924.00	3,506,320.00	242	330
Illinois	3,000,000.00	4,873,134.00	203,554.00	395,068.00	598,622.00	465,000.00	1.29	5,879,638.00	4,170,471.00	402	600
Michigan	2,250,000.00	2,536,015.00	85,139.00	132,479.00	217,618.00	185,375.00	1.17	3,263,993.00	1,583,461.00	179	207
Minnesota	1,200,000.00	745,340.00	19,000.00	107,617.00	126,617.00	107,000.00	1.18	490,174.00	120,353.00	76	115
California	2,700,000.00	2,706,167.00	133,504.00	458,991.00	592,493.00	262,000.00	2.26	3,815,610.00	2,825,234.00	184	300
Arizona	2,000,000.00	1,558,853.00	59,180.00	353,593.00	412,773.00	225,000.00	1.83	1,247,414.00	937,716.00	106	191
Missouri	2,000,000.00	2,538,027.00	154,416.00	(26,131.00)	128,285.00	210,000.00	.61	4,995,679.00	3,723,682.00	202	360
Ohio	2,000,000.00	4,572,963.00	237,937.00	536,756.00	774,713.00	230,000.00	3.37	5,751,005.00	4,350,935.00	327	400
New Jersey	1,700,000.00	1,797,226.00	70,036.00	87,643.00	157,673.00	150,500.00	1.05	1,732,202.00	1,602,563.00	110	199
District of Columbia	4,500,000.00	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	0	380
Florida	1,100,000.00	3,163,221.00	99,457.00	316,214.00	415,671.00	112,750.00	3.69	2,731,718.00	1,956,477.00	128	208
Michigan	1,600,000.00	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	0	136
New Jersey	1,350,000.00	1,231,890.00	32,974.00	106,662.00	139,636.00	112,000.00	1.25	1,329,063.00	1,206,844.00	82	184
Total	44,900,000.00	39,921,553.00	1,957,836.00	3,519,967.00	5,477,803.00	3,446,625.00	1.59	54,724,403.00	38,857,941.00	3,016	5,195
Per bed	2 20,605.78	13,236.59	649.15	1,167.10	1,816.25	1,142.78	---	18,144.70	12,883.93	---	---

¹ New hospital.

² Computed on the 2,179 beds added by new construction; all other "per bed" figures computed on the 3,016 beds before new construction.

NOTE.—The numbers appearing on p. 20 of the testimony were based on a tentative tabulation of the above figures; they are, however, not significantly different from the above.

Source: Prospectuses on file with the Wisconsin State Securities Commission.

Mr. MUELLER. Thank you. A tabulation of recent mortgage loans to hospitals shows the following for 18 hospitals obtaining loans in 1965-1966:

For latest fiscal year:	Per bed
Total operating expenses-----	\$13, 930
Net income-----	1, 196
Depreciation-----	762
Total cash flow-----	1, 958
1st year debt service-----	1, 312
Coverage (cash flow divided by debt service)-----	1.49×1
Average loan per number of increased beds-----	20, 478
Average number of increased beds-----	130

Of particular significance is the fact that coverage was 1.49 times debt service requirements, even based on the earning capacity of the facilities before the expansion took place.

In addition, it is significant to note that the ratio of net income to total operating expenses is 8.5 percent an amount quite consistent with the 5 percent operating expenses allowance previously calculated.

One must conclude that lenders of funds to hospitals recognize the requirement that hospitals be able to earn sufficient amounts in excess of total operating costs to enable them not only to service the debt, but also to maintain a technologically up-to-date facility which can render high-quality service in a competitive atmosphere.

In further amplification of the needs of hospitals for amounts in excess of cost, a preliminary report issued by Arthur Young & Co., CPA's, of San Francisco, Calif., for the California Hospital Association disclosed that for 10 years ending 1965-66, capital improvements, 92 percent of which was for facilities and 8 percent for working capital, in 51 hospitals were financed from the following sources:

[In percent]

	Nonprofit	Proprietary	District
Depreciation-----	27	36	44
Net income-----	23	42	42
Long-term financing-----	19	22	-----
Grants, contributions, taxes, and other-----	31	-----	14
Total-----	100	100	100

The rules and regulations which have to date been published with respect to the definition of "reasonable cost", give every evidence that their authors have been cognizant of the fact that the financial needs of hospitals go far beyond "reasonable cost."

Within the limits prescribed by legislation, much has been done to assist hospitals to meet this need. Such items include the permitted use of accelerated depreciation, the so-called 2 percent factor, and liberal provisions with respect to income earned on funds set aside for plant replacement.

What has been done, however, is grossly inadequate. I cannot say in terms of specific amounts or percentages what would be adequate. Certainly it must be an amount sufficient to cover the types of needs,

over and above current operating costs, which have been outlined above and should, in addition, be adequate to permit the hospital to build a reasonable reserve for future unfavorable contingencies.

Failure of the Congress to permit hospitals to collect at least proportionately as much from medicare patients, as they do from the other patients which they serve represents, in my judgment a shocking inequity which can only be corrected through legislative clarification of the term "reasonable cost" and such action as may be necessary to permit a significant increase in the 2 percent factor.

ADMINISTRATIVE PROBLEMS

Many of the administrative problems which must eventually be coped with have yet to be encountered. These include such matters as annual reporting and the settlement of the many disputes which arise under any program which involves cost-allocation and cost-apportionment procedures.

I will not at this time speculate on these problems, but will predict that they will be of great magnitude. Whether or not they can be reasonably solved, only time will tell.

There are, however, certain current administrative problems which should, I believe, be brought to the attention of this committee. I will limit my testimony to those matters which directly affect hospitals.

Probably one of the most difficult current problems for the typical hospital to cope with, is that brought about by those provisions of Public Law 89-97, which demand that the professional component of hospital services attributed to hospital-based physicians be billed to the patient in such a way that they can be separately identified and charged as an amount reimbursable under part B of the law.

In those instances where the hospital has continued to bill for the services of hospital-based physicians, it has been necessary to segregate charges for tests or procedures which involve the services of a hospital-based physician.

This has made necessary a duplication of rate structure and has interposed a significant additional clerical burden on the hospital. In those cases where hospital-based physicians have elected to bill patients directly, it has caused significant increases in the overall clerical effort involved in the billing process.

In either event, it has resulted in considerable confusion to the patient, be he covered by the medicare program or be he not covered, because procedures such as this are not feasible to inaugurate with respect to any particular class of patient; they must be inaugurated with respect to all patients or not inaugurated at all.

The overall result has been patient confusion and an increase of significance in overall administrative costs.

I would suggest that there should be some basis for a legislative solution to this obviously uneconomic procedure. While I do not presume to recommend a course of action, certainly the inclusion of the services of hospital-based physicians as an element of hospital services would be one way to handle the problem.

If it were considered necessary from the point of view of the Government's internal accounting to distinguish the amount of these charges as between part A and part B, this could be calculated on a

statistical basis periodically and be effected as a transfer of funds internally within the Government accounting system.

Another area which is causing considerable difficulty, particularly in those metropolitan hospitals which have either free clinics or otherwise high outpatient activity, is the distinction between diagnostic studies, which are reimbursed under part A and have a \$20 deductible amount, and therapeutic visits, which are reimbursed under part B, with the customary \$50 deductible limitation. The amount of paperwork necessary to report and collect for these services is staggering, particularly in view of the relatively low dollar amounts involved with respect to each patient visit or treatment.

However, as long as the two programs must be distinguished each with a different deductible amount, and, in the case of diagnostic studies, with a 20-day spell of treatment involved, the paperwork appears to be unavoidable.

The problem is particularly acute in those large teaching and charity hospitals which operate free or semifree clinics. In many of these organizations, the number of medicare visits alone can run as high as 500 per day, and the number of individual charges applicable to these patients can be much higher than this number.

When it is recognized that the services applicable to these visits must be split between those which are diagnostic and those which are therapeutic and that then the professional component of any amounts included in diagnostic must be considered as a part of part B, and in effect, entered as a therapeutic charge and then each of these amounts must be recorded on a daily basis on a separate outpatient reporting form which is submitted to the fiscal intermediary for reimbursement, you can see the tremendous volume of paperwork which is being generated, merely to account for the separate deductibles.

This problem becomes completely incredible when it is realized that, at least in the case of the free clinics, most of the deductibles will be paid for by State welfare departments, many of which are qualified under title 19 of the act. In these instances, the only purpose of this tremendous volume of paperwork is to determine the allocation of the charges between title 18 and title 19.

Certainly one thing that could be done legislatively to help solve this emerging administrative problem is to eliminate the distinction between a diagnostic series presently covered under part A and the therapeutic services includable under part B.

In addition, considerable savings could accrue to both hospitals and the Government if services rendered to the medically indigent in organized clinics could be billed on a mass basis, consisting of monthly listings containing such minimum information as patient name and social security number.

Financial settlements could be made on an average cost-per-visit basis and annual cost reports filed in a similar manner to that contemplated by present regulations. This savings could only be realized if the distinction between part A outpatient diagnostic studies and part B therapeutic and professional services were eliminated.

Thank you, Mr. Chairman, for the opportunity of presenting this testimony.

Mr. ULLMAN. Thank you, Mr. Mueller. Now your next witness.

STATEMENT OF MARK BERKE, AMERICAN HOSPITAL ASSOCIATION

Mr. BERKE. Mr. Chairman, I am Mark Berke, and I am director of Mount Zion Hospital & Medical Center, San Francisco, Calif. I appear here today in behalf of the American Hospital Association as a member of the board of trustees of the association.

Although I will be repeating some aspects of the material already presented to you this morning, I would like to stress certain problems from the point of view of a hospital administrator.

I must remind you, however, that a full evaluation of the impact of the reimbursement formula provided under title 18 cannot be made at this time because there has been inadequate experience with hospitals reflecting fully audited year-end fiscal reports with subsequent retroactive adjustments.

However, there exists a just-completed study performed in California by Arthur Young & Co., a distinguished accounting firm, which I believe responsibly estimates the effect of the present reimbursement formula on hospital revenues by imposing it, the reimbursement formula, upon the actual financial reports for the latest complete fiscal years of the hospitals encompassed by the study—a statistical cross section of California's general, acute, short-term hospitals by both type and size.

I suggest that the statistical survey by Arthur Young & Co., based as it is on actual experience, provides the best possible indicator at this time of the effects of the reimbursement formula on hospitals. This study estimates that 74 percent of the hospitals' studies will receive reduced revenues under medicare's present reimbursement formula.

If I may paraphrase, to conserve time, the study concludes that the formula does not meet its stated objectives, and will not provide sufficient return to allow hospitals to maintain a healthy financial position.

In the case of my own institution, for example, Mount Zion Hospital and Medical Center in San Francisco, most of the patients aged 65 and over were formerly private patients who either paid our regular rates themselves, or their bills were paid by Blue Cross or a private insurance carrier.

We anticipate now, under medicare, that our income from these patients will be reduced by 8 percent, and we have set up a reserve accordingly, which for the year 1967 is estimated to be \$400,000; however, because we are not certain of the total impact on our income, our board of trustees deemed it prudent to add a further reserve of 4 percent, or \$200,000, for a total reserve of \$600,000 for 1967. It will be many months before we know whether these reserves are adequate or inadequate.

My position as president of the California Hospital Association last year gave me the opportunity to hear numerous firsthand reports of a similar nature from hospital administrators from my own and other States. This is further augmented by my work for the last 6 months as a member of the Facilities Panel of the President's Commission on Health Manpower, during the course of which I have been in a position to learn of economic problems of hospitals on a nationwide basis.

I might add here that the Young study shows, and I quote:

Based on services historically provided to medicare-age patients, the net income of the adversely affected hospitals will be reduced by 18 percent.

The administrative procedural problems created by medicare can be grouped into two classifications:

(1) Short-range problems, created by a new, large, and complex program. It is our hope and our expectation that these problems can be solved expeditiously and thoroughly, in the interests of the public for whom the program was created. These were discussed in some detail by Mr. Cartmill; I won't go into them any further.

(2) Long-range problems, actual and potential, which have developed or which will develop because of procedural or financial situations created by both the legislation and the regulations which implement the legislation.

These are such matters as inadequacy for reimbursement of depreciation, problems with insufficient cash flow which I will now discuss.

INADEQUACY OF REIMBURSEMENT FOR DEPRECIATION

You have already heard much cogent comment on this, but permit me to make a few further observations on this subject.

Hospitals that finance the major portion of their plant and equipment through mortgages or bonds have made it quite clear that they are recovering insufficient funds to meet their financial needs through principles 1-1 or 1-11 of HEW's principles of reimbursement for provider costs.

This committee does not need to be reminded by me of the rapid obsolescence of equipment and of the greatly increased sophistication and consequently increased cost of replacements, in an era when technological and scientific advances come upon us with geometrically growing speed; nor does it need to be reminded of the increased costs of construction, as well as the much more expensive buildings that must replace today's obsolete structures.

The Committee must be aware that today's level of care is not the ultimate, but rather than the level of care will continue to advance each year, as will the cost of the buildings and equipment which will be needed to house and support the care rendered to the public.

To provide depreciation on a historical basis rather than at replacement cost is cause for real alarm to all of us in the hospital field, and it seems to me that such a policy will inevitably affect deleteriously the ability of the hospital to bring to its physicians and to the public the up-to-date knowledge and techniques that advanced research is making possible. Rather than bring about the better care that such programs as the Federal heart, cancer, and stroke program were intended to do, failure to reimburse adequately for depreciation will lead to a deterioration in the quality of care because of the hospital's inability to finance the necessary and costly equipment and construction.

The proposal that depreciation be funded and used only as approved by a local or regional planning body is, I believe, sound on both a theoretical and a social basis as far as expansion is concerned, although I do not agree with it when it faces replacements.

However, it must be borne in mind that many hospitals in the United States, I believe a study would show that this is true of the

majority of them, use depreciation to cover operating expenses, because of a lack of working capital.

In our own case, for example, we did not reflect depreciation at our financial statements for many years, because it would have meant a bookkeeping increase to an already large deficit. Roughly 10 years ago, we saw an improvement in our operations, and about 5 years ago we began to show depreciation as an expense.

In 1966, we reflected \$397,330 as depreciation expense, but our cash position allowed us to fund only \$120,000 and that was done with great difficulty.

If we, and other hospitals, are now to be required to fund the whole of the depreciation allowance, it will compound our cash problems, and thus make it all the more imperative that the reimbursement formula permit the generation of an adequate supply of working capital.

CASH FLOW

Another major source of complaint and unrest in the hospital field is the inadequate cash flow that most hospitals are experiencing.

There are a number of reasons for this, not the least of which is the difficult and complex administrative detail involved in the billing mechanisms established among hospitals, the fiscal intermediaries and the Social Security Administration.

Hospitals are making every effort to submit patients' bills promptly; but the slowness of payment hampers us, regardless of where the fault lies. The resultant increase in accounts receivable has been great.

In our own case, for example, at Mount Zion Hospital, our accounts receivable on December 31, 1965, was \$834,338 whereas on December 31, 1966, it was \$1,567,119. Part of this remarkable increase was due to an increase in our bed complement, but we estimate the increase due to medicare patients was \$300,000.

Perhaps a more reliable comparison is the number of working days revenue outstanding, represented by accounts receivable. On December 31, 1965, it was 41 days outstanding, whereas on December 31, 1966, it was 50 days for an increase of 22 percent.

Other hospitals have had similar experiences. California Hospital in Los Angeles informed me that it has had an increase in accounts receivable from \$827,982 or 45 days revenue, on December 31, 1965, to \$1,255,642 or 55 days revenue on December 31, 1966, with no increase in bed complement.

Saint Luke's Hospital in San Francisco reported an increase from \$460,369 or 28.6 days of revenue to \$762,032 or 47.5 days of revenue for the same period with no increase in bed complement.

We recognize that the advance payment is intended to provide working capital for the increase in accounts receivable, but this is only of temporary help, since the advance must be repaid within a month or two.

Another major factor that adds to our financial burdens is the higher cost of operations due to labor increases, to increased costs for materials and supplies, and to the effects of the regular inflationary spiral.

These wage patterns are reflected in national cost analyses and predictions. Hospitals are particularly vulnerable to the impact of changes in salaries and wages. Salary cost accounts for 60 to 65 per-

cent of hospital expense. During 1966 hospitals were subjected to the first major break in the pattern of wage escalation since 1946. During the past year salaries for nurses in many parts of the country have risen 15 to 20 percent.

Data on nursing service salaries from a random selection of 38 hospitals across the country shows the following increases: In 12 hospitals from 20 to 30 percent; in 11 hospitals from 10 to 20 percent and in 15 hospitals under 10 percent from November 1965 to November 1966.

The above data was obtained from hospitals participating in the hospital administrative services program of the American Hospital Association. The monthly reports prepared for the participating hospitals provide operational statistics for the administrator and include comparative data for current and preceding months plus data for hospitals of similar size in his state as well as nationally. As yet the hospital administrative services reports do not reflect all of the adjustments made because of the minimum wage requirements that became effective February 1, 1967.

Indicative of the administrative detail required of medical records departments under Medicare—there is just one example, Mr. Chairman—is the following information abstracted from H.A.S. report. The medical records direct cost per 100 beds, that until June 1966 indicated seasonal variation and normal salary increases, showed a sharp increase of 8 percent from June through November 1966 as compared to the costs in 1965.

Another source of data available to the American Hospital Association is that compiled from a statistical sample of over 600 hospitals on a monthly basis. These trend reports called hospital indicators are published monthly in *Hospitals*, journal of the American Hospital Association.

For the period September 30, 1965 to September 30, 1966 the following statistical data were obtained from hospital indicators reports:

	Yearend, Sept. 30, 1965	Yearend, Sept. 30, 1966
Average salary, all personnel (per annum).....	\$4,072.00	\$4,382.00
Salary expense per patient-day.....	27.44	29.88
Other expense per patient-day.....	17.04	18.95
Total expense per patient-day.....	44.48	48.83

Thus between September 30, 1965 and September 30, 1966 the total expense per patient day increased 9.8 percent.

Using hospital indicators information plus supplemental cost studies on nurse salary increases, the following cost increases are anticipated between September 30, 1966 and September 30, 1967:

	Yearend, Sept. 30, 1966	Yearend, Sept. 30, 1967
Average salary, all personnel (per annum).....	\$4,382.00	\$5,140.00
Salary expense per patient-day.....	29.88	36.90
Other expense per patient-day.....	18.95	21.03
Total expense per patient-day.....	48.83	57.93

Thus we anticipate an 18.6 percent increase in total hospital expense per patient day from September 30, 1966 to September 30, 1967 or from September 30, 1965, to September 30, 1967, an increase of 30.2 percent in the total expense per patient day.

The following figures from hospital indicators have just been compiled for the month of December 1966: Total expense per patient day, \$56.69; salary expense per patient day, \$35.28; and other expense per patient day, \$21.41. When the above cost data are compared with December 1965, we find that the total expense per patient day increased 14 percent, salary expense per patient day 15 percent, and other expense per patient day 12 percent.

The utilization of hospital inpatient facilities under medicare are reflected in the following statistics on admissions and average length of stay. Source: Hospital indicators.

	Percent of admissions 65 and over	Percent of patient-days 65 and over	Average length of stay (days)		
			Under 65	Over 65	Overall
July.....	19.2	28.2	7.8	11.2	7.6
August.....	17.8	28.6	6.5	12.0	7.5
September.....	18.9	30.0	6.8	12.5	7.9
October.....	19.0	30.0	6.9	12.6	8.0
November.....	19.2	30.2	7.0	12.7	8.1
December.....	19.4	32.0	6.8	13.3	8.0

In California, and in the west coast generally, nurses' salaries went up, between July 1966 and April 1967, approximately 36 percent; and salaries for 18 other hospital employee classifications increased from 10 to 30 percent.

In the case of Mount Zion Hospital and Medical Center, this means that our payroll will increase \$1,180,000 over a 12-month period, and additional increases are scheduled by union negotiations during 1967. In the case of Saint Luke's Hospital, in San Francisco, the increased cost is \$349,454, and at California Hospital in Los Angeles, it is \$600,000.

One of the results of the obviously deteriorating cash position has been, as one would expect, slowness of payment to our vendors, and I have personally spent hours on the telephone trying to explain to businessmen why we are not paying our bills on a current basis.

I am under no illusion that we are not paying a premium for this delay—it is obvious that the hospital, and therefore the public, must be charged extra for extended credit.

Despite the cash advances, which I have already explained can have only a temporary effect, many hospitals have had to borrow money for operating purposes. For example, on February 5, 1967, Mount Zion Hospital and Medical Center borrowed \$350,000 from the bank in order to pay its bills.

Our board of directors discussed the matter for many months before this step was taken, because we did not know, and we still do not know, how we can repay the principal, in view of the fact that the reimbursement formula does not allow for the generation of working capital.

ADMINISTRATIVE PROBLEMS

The understandable complexities of this vast program have created additional administrative burdens for all hospitals and this, of course, was to be expected. Many hospitals, however, have been forced to increase the number of personnel, particularly in the business offices, thus adding a cost item, only a part of which is reimbursable under the formula.

At the same time, the costs of preparing bills for out-patient services are frequently greater than the small amounts received in payment for the services rendered.

Equally important is the problem of the hospital-based specialists, which I will not dwell on now, since Dr. Graham will cover this shortly. I urge you, however to give serious consideration to his observations and comments, because administrators are currently spending far too much of their time on this sort of problem, thus channeling their talents away from the making of positive contributions to the improvement of patient care.

Every effort must be made to solve these problems, all of which are secondary to the provision of patient care, and all of which add burdens to the already critical shortage of manpower available to accomplish complex activities on all levels.

METHOD OF PAYMENT

It is difficult to argue logically and in businesslike fashion against a system that is intended to make each recipient of a service pay the full cost of that service, and that attempts to preclude the payment by any given patient of costs incurred by others. Such a system works only when applied to all patients, of course, and this has important implications for the pricing of services and the recovery of costs.

We have developed an excellent voluntary hospital system in the United States, as attested to by all objective observers, including many foreign visitors, who are liberal in their admiration of our programs. There are numerous reasons for the high quality and standards of our voluntary hospitals, and one of them is the flexibility we have possessed in the development of new programs, such as the dramatic open heart surgery advances of recent years.

While costs have always concerned us, they have not deterred us from growth and development because we have been able, when necessary, to spread the cost among large numbers of patients rather than charge a few patients the extremely high costs their illnesses dictate.

An example of this is the intensive care unit, a service adopted quickly by many hospitals since its effectiveness was first demonstrated a few years ago. At Mount Zion Hospital and Medical Center, we estimate our costs per day in the intensive care unit to be \$115, whereas our charge to patients is \$64.50. California Hospital in Los Angeles, with a cost of \$100, has a charge of \$65. The intensive care unit is a lifesaving service, and we learned early that if we attempted to recover the full cost from each patient, there would be resistance by the patient to the use of the facility and that this would result in unnecessary deaths, or in unduly long, complicated and costly hospitalizations.

The coronary care unit is a similar development. At California Hospital, this costs \$120 per day, whereas the charge to the patient

is \$65, for the same reason. When Dr. DeBakey's heart transplantation becomes a routine procedure, it will obviously be extremely costly.

Shall we then deny it to all but the very wealthy, as we will have to do if the cost of the procedure is borne only by the patient receiving the service? It seems obvious to me that if this direction continues, hospitals will be loath to introduce new programs, no matter how lifesaving they may be, in view of the inability of the individual receiving the service to pay for it, and with no opportunity to apply the insurance principle of spreading the risk, and the cost, over many.

It may be argued that such advanced procedures as heart surgery and organ transplant affect only the few. There are other, more common, examples bearing vital sociological implications. The present system of reimbursement places an additional financial burden on the millions of young parents just getting their start as independent citizens of our great Nation. I refer, of course, to maternity and pediatric care. Accurate figures are hard to come by because, as I indicated earlier, most hospitals spread such costs among a large number of patients.

However, since the early 1930's, county hospitals in California have been required by law to maintain an accurate charge structure related to their costs. I have information from Gordon Cumming, administrator of Sacramento County Hospital, that his institution is contemplating new charges in the maternity department that will total \$441.84 for a 4-day stay for mother and baby. A comparable figure at Mount Zion would be \$357.

The difference is attributable to the fact that we do not charge at our full costs for all services for our maternity patients. This difference, of course, must be made up by other patients. The difference could be even greater.

At Sacramento County, for example, they charge a flat \$60 for the use of the delivery room. Many other hospitals charge by the hour for the delivery room.

An example of what an hour-charge could do can be seen at Alexandria Hospital in Alexandria, Va. As reported in U.S. News & World Report on January 23, 1967, pages 63-64, the charge for use of a delivery room is \$43 an hour. However, on the basis of actual accounting, the cost of the delivery room is \$125 per hour.

I think it behooves us to consider what we are doing to our total system of medical care and not simply to the cost of the medicare program. Before we force changes on a system that has been proven by its results, we should be sure that the changes will both produce a better system than before and be worth the cost to the country.

In short, gentlemen, the Congress of the United States has guaranteed medical care to a large segment of its population, and has asked the medical community to join in a partnership with the Government to provide the care. We want to do this.

If we are to do it well, and if we are to continue as a dynamic, growing source of medical care providing leadership not only to this country, but also to the world, we ask you to help us meet these administrative problems; to assure us an adequate amount of working capital to do the job that must be done; and to think through with us the total impact of Government programs on the health system of the

United States, recognizing that our requirements for the rendering of a high quality of patient care go beyond the discipline of pure and raw accounting.

Mr. ULLMAN. Thank you, Mr. Berke.

STATEMENT OF DR. GEORGE W. GRAHAM, AMERICAN HOSPITAL ASSOCIATION

Dr. GRAHAM. Mr. Chairman, I am George W. Graham, director of Ellis Hospital in Schenectady, N.Y., and a member of the board of trustees of the American Hospital Association. My testimony will present the views of the American Hospital Association on those portions of H.R. 5710 the Social Security Amendments of 1967, pertaining to coverage of hospital-based physician services and outpatient department benefits.

COVERAGE OF DIAGNOSTIC SPECIALTY SERVICES FOR INPATIENTS

The evolution of the American Hospital has resulted in a close tie between the institutions and certain diagnostic medical specialists. Today to have an effective hospital, it is essential to feature quality laboratory and radiology services and these necessitate the personal services or supervision of a radiologist and a pathologist.

Although these specialists are full-fledged physicians with formal residency training behind them, the peculiar nature of their ministrations has caused them to be treated differently than most practicing physicians.

That is, unlike other members of the medical community and for most of their professional responsibility, they do not have a direct physician-patient relationship. Most work in a hospital under a contractual arrangement. Few patients ever meet the radiologist or pathologist who serve them in the hospital and thus it is more convenient for all concerned to have the services of these specialists billed by the hospital as an integral part of hospital services. Hospitalization insurance coverage has generally recognized the in-hospital activities of radiologists and pathologists as a part of normal hospital services and has paid accordingly.

At times there have been policy differences between the organized medical specialists and the hospital field and at other times there has been a reasonable level of agreement. When the medicare legislation was being considered by the Congress, a request was made on behalf of the radiologists and pathologists for them to be treated under the statute in the same way as any other medical practitioner.

The legislative acceptance of this request succeeded in splitting off from the hospital the payment for services of hospital based radiologists and pathologists.

Consequently, the established billing system prevailing in the majority of hospitals could not be utilized for medicare patients. While the hospital portion of the radiology and pathology service to medicare patients is now billed as a hospital expense under part A, the other segment, compensation of the specialist, professional component, has to come only from part B. The result of this legislation inflexibility has been intense administrative difficulty.

For example: 1. A medicare patient with no part B coverage has to pay the radiologist and pathologist directly and in full. The fact that the patient may never have met this practitioners presents many public relations problem between patients, specialists and hospitals.

2. Even where the specialist is a salaried employee of the hospital, it is necessary to determine how much he is paid for a particular service and then he, or his collection agent, for example, the hospital, must file for compensation under part B.

3. The patient, who has already been subject to a \$40 deductible upon entering the hospital, must also face application of the \$50 annual deductible under part B to radiologists' and pathologists' services, as well as the additional 20 percent coinsurance; the net result is that the patient pays for most of the radiologists' and pathologists' fees for inpatient diagnostic work even if he does have part B coverage.

4. In the case of pathology services, and to a lesser extent in radiology, the professional component of some procedures is small and the amount of benefits covered by medicare even smaller; in many instances the cost of administration of the claim far exceeds the payment involved.

5. The most common arrangement between hospital and medical specialists has been a percentage contract, where the hospital bills for the entire diagnostic service and pays the specialist an agreed percentage of the charge as his personal compensation.

Because medicare generally requires billings for the specialists' compensation for each procedure performed, many specialists have considered changing their contract so that there will be a single arrangement for medicare and nonmedicare patients alike.

The result is to add to the administrative cost, if not to the specialist's fees, without increasing the quantity or quality of services received by any of the patients.

6. It is extremely difficult to determine the specialist's component for each procedure in which he has some involvement and desires payment under medicare. Reports from hospitals and intermediaries show the billing for these separate components takes twice as long as for the customary combined billing under other third party payment plans.

Over a period of more than two decades the American Hospital Association has maintained the policy that it is the right and responsibility of hospitals and physicians to develop on the basis of local conditions and needs, terms of service which are fair and equitable and are designed to provide high-quality care to patients. The Association continues to hold to the position that good patient care is being provided in hospitals under a variety of agreements.

The freedom of the specialist to exercise his medical judgment and to obtain an adequate remuneration for his services is not at issue.

We continue to hope that the medicare statute will not force inconvenient and expensive arrangements on hospitals and medical specialists as long as the parties are able to reach agreements satisfactory to them and beneficial to the patients.

We note with approval the proposed amendments in H.R. 5710 insofar as they transfer the part A coverage all the inpatient diagnostic X-ray and laboratory services. We further approve the resulting elimination of the \$50 deductible and the 20 percent co-

insurance applicable to inpatient diagnostic services of radiologists and pathologists.

We understand, also, that a specialist engaged on a salary would not have to execute an assignment to permit the hospital to bill for his services. A specialist on a percentage contract could do his own billing for his inpatients if he likes, or assigns his rights to the hospital and thus make it possible to submit a single bill to the part A intermediary for all inpatient hospital services.

This flexibility is lacking in the present status. Of course these proposals eliminate the risk of nonpayment which hospital based radiologists and pathologists have faced until now because of the \$50 deductible and 20 percent coinsurance, applicable even to inpatients, and because some patients may not have part B coverage.

The American Hospital Association would like to see therapeutic radiology services covered on an inpatient basis. We recognize that on rare occasions a hospital admission might be solely for therapy which could be provided less expensively on an outpatient basis, but at a greater personal cost to the patient.

We would trust to the judgment of the attending physicians to prevent any such abuses. There is much merit in not singling out one in-hospital function, such as radiation therapy, for exclusion as a hospital benefit, with attendant administrative inconvenience.

We hope that the administrative burden for hospitals may truly be lessened so that, with the specialist's cooperation, the hospital based physician's personal remuneration need not be separately stated when the total hospital bill is submitted to the Part A intermediary.

If necessary, a periodic review by representatives of the government, could consider whether the hospital's payment to the specialist represents a reasonable charge. In this way the part A trust fund can be protected against unreasonable demands.

BENEFITS FOR HOSPITAL OUTPATIENTS

Social Security Commission, Robert M. Ball, told an American Hospital Association meeting last month:

It seems to me that as result of our experience during these first seven months of medicare, we can all agree first that—in the interests of the patient and in the interest of the sanity of all those who have to do with the administration of the program—there need to be major changes in the legislative provisions governing outpatient hospital benefits and reimbursement for the services of hospital-based specialists.

Although the outpatient diagnostic benefit would have been difficult enough to administer if there were only a Part A program, the addition of the Part B voluntary program on top of this benefit has created a just-about-impossible situation.

In the outpatient department, for purposes of reimbursement, distinctions must be made between physicians' and non-physicians' services, between diagnostic and therapeutic services, and between services that, though diagnostic, do not reach \$20 within a 20 day period and those that do.

Hospitals must keep track of small charges that are never reimbursable to them but are reimbursable to patients under the voluntary part of the program . . . All in all we have in the provisions governing this benefit, I believe, most of the aspects of the program that lead to charges that medicare is a snarl of red tape or a bureaucratic nightmare, et cetera.

To this I add "Amen."

The existing provisions for outpatient services in hospitals are restricted to diagnostic activities. They are divided between part A and

part B and subject to two different deductible amounts as well as co-insurance limitations.

Payments toward one deductible can be credited toward the other. The provisions are all but impossible to explain to the beneficiaries, to understand, and to administer. Nor are they worth the administrative agonies because neither hospital, diagnostic specialist, nor patient obtains sufficient payment to compensate for the troubles encountered.

The patient who desires outpatient diagnostic service in the hospital, in our illustrative example, receives total services amounting to, let us say, \$60. Immediately, it is necessary to split the charges into two components, the hospital's reasonable cost and the physician specialist's reasonable charge.

Assuming the cost accountants can accomplish this task, perhaps this hypothetical patient has received \$35 worth of hospital services and \$25 of medical care. The \$35 cost is charged to the part A intermediary, but not all of it for the patient must pay the first \$20, or some other government agency must do so or else the hospital incurs a bad debt.

The same is true for the 20-percent coinsurance applicable to the \$15 balance, or \$3.

The \$25 medical fee is transmitted to the part B carrier, even if the doctor is a salaried or contractual member of the hospital staff. If the patient does not have part B coverage, the doctor receives no payment unless he can obtain it from the patient or from a welfare agency.

Should the patient be covered under part B, he must have satisfied the annual \$50 deductible amount before his outpatient diagnostic physician's services will be paid for, and even then he must pay 20 percent of the bill, in our example, \$5, as coinsurance.

If this is clear so far, we must take into account a few more details. Should the patient have failed to meet his \$50 deductible under part B, he may apply the \$20 outpatient deductible under part A towards the \$50 deductible under part B. But if he enters the hospital within 20 days of receiving the outpatient diagnostic services, the \$20 hospital outpatient deductible may be applied against the \$40 inpatient deductible.

The mind reels at this onslaught of rules, statistics, and interrelationships. It is no wonder that few hospitals, physicians, and patients have fathomed the maze sufficiently to receive payment. More frequently than not the administrative costs to the hospital, physician, intermediary and carrier, have exceeded the payment. The patient in our example received \$60 worth of services for which there was medicare reimbursement for at most \$32, and only \$12 if he had not yet met the \$50 annual part B deductible in full, and there were at least two sources of payment.

Some hospitals, I have heard, are delaying billings for outpatient diagnostic services. In my particular hospital we are not, but I would like to read a note sent to my controller in answer to an inquiry concerning delayed billings:

Small balances billed, the additional paper work required to bill the intermediary, to record small partial payments, to bill patients minor amounts due from them after medicare has run its course, are more expensive to process than was the cost of making the examination. There are many 18 cents and 20 cents transactions which cost us more in computer costs alone than the payment made.

Even when billed, patients tend to ignore minor balances of this sort because they, too, have to spend more to pay them than it is worth.

A serious handicap is the 20 day delay in billing outpatient services in order to pick up diagnostic series. Accounts set up as the services are rendered must be consolidated in billing. After the payment formula has been applied, a check is received for a group of accounts and there is no way of readily determining how much of each account receivable is being liquidated. If none of the charges are set up on the books in order to develop one consolidated account, the hospital is forced to forego booking its revenue until three weeks after rendering the service. This is not good accounting and it creates serious problems of trying to coordinate medical statistics and charts with charges incurred.

In general, our costs of handling paper work have significantly increased the cost of patient care. Time required to do this has increased the cost of financing patient care by doubling our investment in accounts receivable. It seems that strenuous effort should be made to eliminate the duplicate handling by the Part A intermediary and the Part B carrier.

I refrain from swelling the record of these hearings with sample forms I have with me showing the many instances of payments to hospital or specialist of less than a dollar and coinsurance due from the patient of a few cents. One patient sent us his coinsurance obligation for laboratory work—16 pennies, scotchtaped to a piece of cardboard.

Surely remedial action is essential.

The proposed amendments represent a step in the right direction.

Unfortunately they alleviate only part of the difficulties. What remains is still a more complicated program and administrative burden than can be justified. The commendable changes which we approve would—

Eliminate the \$20 deductible for hospital outpatient services as well as the applicable 20-day period of limitation.

Cover a broad range of outpatient hospital services in addition to existing diagnostic benefits.

Permit billing for outpatient services via a single bill, including the reasonable charges of the radiologist or pathologist, if the physician-specialist is agreeable.

Less desirable are these proposed changes which we do not support:

Barring any outpatient coverage to those older patients who, for whatever reasons, do not have part B protection.

Retaining the high deductible and coinsurance requirements for outpatient physician services and imposing them on hospital outpatient services, as well.

Thus, the simplification accomplished by the proposed amendments, primarily to place all outpatient benefits under part B coverage, does not significantly reduce the high cost to the patient, or the inexplicable complexity of the program. It would continue to delay the final reimbursement of hospitals under part A because it takes so long for the hospital to know what its bad debt situation might be due to possible imposition of deductible and coinsurance, as well as competition, in some cases, with a physician for the patient's dollars to pay for deductible and coinsurance charges.

This Association recognizes the financial considerations which necessitate some deterrence in the area of outpatient coverage. We believe, though, a sufficient deterrent to unnecessary use of outpatient benefits may be accomplished by a single coinsurance requirement and without a deductible at all.

In this vein we seriously suggest that the new part C, as it applies to outpatient services, create different terms of eligibility and payment than prevail for either part A or part B.

We propose:

1. All persons eligible for part A benefits be covered under part C irrespective of their purchase of the voluntary medical benefits under part B. This would provide comprehensive outpatient diagnostic and treatment benefits for perhaps one-fifth of all persons over 65 years of age who do not have part B coverage and are probably the most medically needy among the aged.

2. In lieu of a high deductible of either \$50 per year or \$20 per diagnostic study, there would be only coinsurance, but no deductible. The level of coinsurance could be altered from time to time, as actuarial studies indicate, so as to keep the total cost of outpatient services within the financial limitations of the trust fund. The coinsurance would deter casual use of the benefits but would not dissuade persons from seeking medically necessary care.

3. With the cooperation of physicians serving in the hospital outpatient department, their reasonable charges would be submitted to the fiscal intermediary as part of a single bill from the hospital. The physicians and the hospital would work out arrangements for dividing the payment received from the intermediary and for collecting the coinsurance amount from the patient or responsible third party.

4. If the outpatient department physician prefers to do his own billing, the intermediary would compensate him at the appropriate percentage of his reasonable charge and he would obtain the balance; namely, the coinsurance amount, from the patient or responsible third party. The hospital, of course, would also obtain reimbursement from the intermediary for its reasonable costs of rendering care to the outpatient, less the applicable coinsurance amount.

5. To the patient receiving outpatient services it would make no difference whether the services he receives are all medical, all hospital, or a combination of both. There would be a single coinsurance percentage applicable to all such services. He would know immediately just how much medicare would pay and what balance would be due from the patient's pocket, his private health insurance, or possibly from a welfare agency.

6. None of the parties involved would need to be concerned with whether the patient had met an annual deductible as yet, nor would there be need for any crediting of payments from one part to another. Each transaction would stand alone.

Our proposal for a meaningful part C benefit program has the advantage, we submit, of administrative simplicity; it is potentially understandable by the patients; and it need not necessarily increase costs to the applicable trust fund.

I sincerely hope these remarks will prove helpful to the committee.

Mr. ULLMAN. Thank you, Dr. Graham, for your statement and your fine recommendations. Dr. Crosby.

STATEMENT OF DR. EDWIN L. CROSBY, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Dr. CROSBY. Mr. Chairman, I am Edwin L. Crosby, the executive vice president and director of the American Hospital Association. I, too, appear in behalf of the association.

In order to be as helpful to the committee as possible in its deliberations, we asked a number of persons to appear here today to present

testimony and to participate in the overall discussions of medicare and its impact on the hospitals of the Nation. As you are aware, the group included a number of individuals who are in no way salaried employees of hospitals but are deeply involved and thoroughly informed on hospital operations. We felt the independent nature of their testimony would be of special value.

Also in the group from which you have heard is a number of highly respected and widely recognized professional hospital administrators from various geographic sections of the country. We sincerely hope that the total impression of the testimony presented reveals our deep dedication to the successful implementation of the medicare law and a common desire to make any corrections which are deemed to be necessary to that end.

The American Hospital Association has devoted an enormous amount of time, energy, and substantial financing to keep hospitals fully informed and to work continually with the Federal administrators of the medicare program and the administrative intermediaries working in the program, and I would repeat the statement made by our president, Mr. Cartmill, at the start of these discussions, that none of us is here to condemn medicare or belittle its accomplishments but rather we are here to present and discuss ways and means for strengthening the program and insuring its full usefulness to the country.

I should like also to express the appreciation of hospitals for the role assigned the administrative intermediaries. We believe that the wisdom of the Congress in making possible such a relationship has been amply demonstrated. I very much doubt that medicare would have developed as smoothly and effectively as it has without the work of Blue Cross and the other intermediaries.

Within the various presentations made in behalf of the association, there is a variety of recommendations. Following are the specific details of recommendations we wish to make in respect to H.R. 5710 and in respect to titles 18 and 19 Public Law 89-97.

NONCOVERED INDIVIDUALS

Some means should be found for providing protection to those individuals who reach age 65 after January 1, 1968, and who are not protected under either railroad retirement or the social security program.

HOME CARE PROGRAM

The programs offered under part A and part B should be brought into conformity as to eligibility and benefits.

CERTIFICATION

We support the amendment removing the requirement of the physician's signature certifying need for care at the time of admission.

LEGAL RESPONSIBILITY

It would be well for the Federal Government to express an opinion as to any legal liability a physician may incur because of his participation in the utilization review process.

TITLE 19

The provision as to the payment of reasonable cost for hospital care should be extended to make sure that care in extended care facilities and skilled nursing homes will also be paid for on the basis of reasonable cost.

INCLUSION OF FEDERAL FACILITIES -

We urge that the amendment to provide payment for care in Federal facilities be rejected and that payment for care in such facilities be restricted as it is at present to emergency conditions.

REIMBURSEMENT

There was considerable discussion on reimbursement and the problems we are facing now by Mr. Miller of Arthur Andersen and his cohorts from the other certified public accounting firms. I should like to say that we are making several studies in this area. Some of these have been alluded to in the presentation, and we would like to file with you at a later date these studies which are being made by the American Hospital Association.

The CHAIRMAN. We will be glad to receive them, Dr. Crosby, for the record, without objection. (See p. 751.)

Dr. CROSBY. We urge that nonprofit hospitals be reimbursed on a basis which will insure them a healthy growth and development. This will require a change in the present bare subsistence basis of reimbursement. Specifically the reimbursement should be corrected so as to recognize replacement cost—the need for additional growth and development funds—and the need for funds to amortize existing debt in those hospitals force to borrow to obtain the necessary capital funds.

The handling of various special purpose donations under “reasonable costs” is at present inequitable to both hospitals and the original donors. We recommend that all special-purpose donations made to hospitals prior to the enactment of medicare not be used in offsetting operating expense.

We recommend that the legislation be amended to permit reimbursement on the basis of average cost, instead of the well-known RCC formula, or not so well-known, as well as any more sophisticated method which might be developed on a sound basis for each individual hospital.

The present recognition given to the financial needs of hospitals under reasonable cost reimbursement is grossly inadequate. We strongly recommend an immediate legislative clarification of the term “reasonable cost” and such other action as may be necessary to permit a significant increase in the 2-percent factor that is now allowed the nonprofit hospitals.

DEPRECIATION FUNDING

This is a rather new and novel idea. Under the existing inadequate formula of reimbursement to health care facilities the proposed rigid control over the use of depreciation funds is totally impractical.

We recommend that any control over depreciation funds by planning bodies should be limited to expenditures for the creation of new facilities or the expansion of existing facilities.

We oppose the provisions of the legislation which would require approval of State planning authority for the replacement of equipment and other expenditures that fall within the area of normal operations of health facilities.

We oppose the provisions which would authorize control over the expenditure of depreciation monies received by hospitals from sources other than the Federal Government. We also oppose the proposal which would permit the Federal Government to withhold payment in future reimbursement for facilities or services which were developed contrary to the recommendations of a planning body.

The present language appears to provide only for a single State planning authority. We believe this is unwise and that specific assurance should be given in the legislation that approved voluntary regional planning organizations would be used. We assure you that the hospitals of this country will continue to operate as efficiently as possible.

Further we do not find a proper appeal mechanism nor do we find any recourse for an institution against which action was taken by the Government and where it was later found the planning agency was in error.

We would be less than forthright if we failed to point out that the legislative proposal as presently drafted for the handling of depreciation funds may well cause the boards of trustees of a great many hospitals to feel that their involvement in the medicare program jeopardizes their legal responsibility for the operation of their hospitals and cause them to reconsider their contractual participation in the medicare program. Mr. Eppert talked about this quite eloquently.

PHYSICIAN SPECIALIST SERVICES

We approve of the coverage under part A of the personal remuneration of hospital-based physicians rendering professional diagnostic services in radiology and the laboratory.

We applaud the flexibility of permitting the radiologist or pathologist to agree to billing by the hospital, including the hospital-based specialists reasonable charges, via a single bill submitted to the part A intermediary.

We are pleased with the elimination of the \$50 deductible and 20 percent coinsurance applicable to inpatient diagnostic X-ray and laboratory services.

We recommend adding coverage of inpatient radiology therapy under part A; this is one remaining radiology service unnecessarily subject to the part B deductible and coinsurance although it is an in-hospital activity.

OUTPATIENT COVERAGE

The proposed legislation does well to eliminate the \$20 deductible for each diagnostic study, as well as the 20 percent coinsurance and the 20-day period of limitation.

Extension of outpatient benefits beyond mere diagnostic services is most commendable.

A single bill for all outpatient services is made possible, with the cooperation of hospital-based physicians in the outpatient department, and administrative problems are thereby reduced.

We do not like the discrimination against persons who have failed to purchase part B coverage and thus are barred from even the very limited outpatient benefits they now enjoy.

Placing all outpatient services under part B subjects the patient to a very high deductible, as well as coinsurance, and continues the administrative complexities for hospital, physician, and patient.

We suggest for part C, instead of the bill's proposals, placing all outpatient services under hospital insurance, subject to no deductible but to a possibly higher coinsurance with physician and hospital permitted to agree to a single billing process for all outpatient services. Such a program allows each transaction to stand by itself, easily understood by all involved, and permits adjustment of the required coinsurance percentage to meet the financial limitations of the appropriate trust fund.

I would just like to add as far as outpatient coverage is concerned many hospitals have said that the present procedure is a nightmare and an incredible mess, and we feel that our part C recommendation will be very helpful in taking care of that.

In closing, Mr. Chairman, I would like to bring to your attention an additional matter which would require an amendment to the Internal Revenue Code and which we hope the committee will incorporate in H.R. 5710.

I know that all of us, this committee, the Members of Congress, the President of the United States, the entire Federal Administration, and most of all, the public, are greatly concerned with the costs of health services. As we have pointed out, the primary reason for cost increases in hospital care is rising wages. Federal legislation already passed is a contributing force behind such widespread increases. Hospitals are well aware of the serious nature of the problem and are looking into all aspects of their operations in an attempt to better control costs.

One area of great promise is joint type ventures in which a number of hospitals can engage, such as a cooperative laundry serving a group of hospitals in a community, a joint purchasing organization, a combined electronic data processing endeavor, and other possible centralized organizations which can serve groups of hospitals in diverse activities.

The development of such enterprises is at present almost completely frustrated because the Treasury and the Internal Revenue have refused to recognize their entitlement to exemptions under section 501(c)(3) of the Code, the same exemptions enjoyed by the participating hospitals—each of which could conduct the same activity independently, though less effectively and economically.

I will not at this time burden you with the details, but I assure you of the necessity of obtaining the desired exemption before we can take advantage of the benefits inherent in the joint activities of hospitals.

For over three years we have had discussions with the various interested federal agencies hoping for satisfactory administrative relief. We know that the office of the Secretary of Health, Education, and Welfare, the Surgeon General of the United States Public Health

Service, the Chairman of the House Interstate and Foreign Commerce Committee, and other distinguished members of the Congress have written to the Secretary of the Treasury and to the Internal Revenue Service urging action on their part to make possible development of the sort of cooperative hospital endeavors I have mentioned here.

All of our efforts have been to no avail, and we have come to the conclusion, therefore, that such desirable activities will be fully implemented only through legislative change.

Accordingly, we submit with this statement a draft of an amendment to H.R. 5710 which would accomplish the tax exemption we have discussed. We believe the amendment is of particular interest to this committee because of the potential savings which would accrue to the Federal Government in the operation of titles 18 and 19 without any loss of income tax revenue. We believe such an amendment is in keeping with the strongly expressed desires of the President of the United States as he has repeatedly emphasized his concern with the rising costs of health services.

We strongly urge the adoption of the tax amendment which we have attached along with a short statement of its purposes.

I appreciate the opportunity of appearing before this committee. We recognize the enormity of the responsibilities of this committee and we sincerely hope our discussions here today have been helpful to your purposes.

Thank you very much.

(The amendment and explanation referred to follows:)

AMENDMENT PROPOSED BY THE AMERICAN HOSPITAL ASSOCIATION TO H.R. 5710, TO ADD A NEW PARAGRAPH (18) TO SECTION 501(c) OF THE INTERNAL REVENUE CODE GRANTING TO CERTAIN JOINT ENDEAVORS ORGANIZED BY HOSPITALS THE SAME TAX EXEMPTIONS ENJOYED BY THE HOSPITALS

(18) Organizations, otherwise meeting the requirements of paragraph (3)—

(A) all of whose owners or members are—

(i) hospitals referred to in section 503(b) (5) which are exempt from tax under subsection (a),

(ii) hospitals which are a constituent part of an organization described in paragraph (3) which is exempt from tax under subsection (a), and which if organized and operated as a separate entity would constitute an organization described in paragraph (3), or

(iii) hospitals which are owned and operated by any one or more of the following: the United States, a State, the District of Columbia, or a possession of the United States, or a political subdivision or any agency or instrumentality of any of the foregoing,

and

(B) whose activities are limited to the performance of services and functions, solely for their owners or members, which, if performed on its own behalf by an owner or member that is exempt from tax under paragraph (3), would constitute an integral part of its exempt activities.

For purposes of this title, the performance of such an activity by such an organization shall be considered a charitable purpose (constituting the basis for its exemption under subsection (a)), and such an organization shall be considered to be a hospital referred to in section 503(b) (5) and described in, or exempt from taxation under this subtitle by reason of, paragraph (3). In addition, for these purposes such an organization shall be considered to receive its financial support from the same sources as do its members.

EXPLANATION OF PROPOSED AMENDMENT TO THE INTERNAL REVENUE CODE

The proposed amendment to the Internal Revenue Code, creating a new section 501(c) (18), is necessitated by the inability of the Treasury or the Internal Revenue Service to find authority in the present statute to grant the exemption we

require. In an effort to reduce hospital operating costs, it has been proposed by many, including the Public Health Service and the President, that hospitals join together to pool their resources and scarce personnel, make maximum use of equipment and plant, and avoid expensive duplication of material and services. In many communities this has been done. A group of nonprofit hospitals has created a single entity to perform activities that the member hospitals have been doing by themselves, such as laundry, purchasing, record keeping, or diagnostic laboratory services.

Clearly, when a tax exempt hospital performs these functions for itself, there is no tax problem. When a hospital performs these services for other hospitals, or joins with other institutions to create a joint venture, tax exemption is denied to the entity conducting the joint activity. The reasons given by the Service are:

(1) Under the regulations to section 502 of the Internal Revenue Code, the group, joint or cooperative efforts of hospitals would be "feeder" organizations, intended to feed profits of business ventures to the exempt institutions. The regulations also deny tax exemption where the organization has a "multiple parentage" made up of nonprofit organizations.

(2) Even if the joint activity were not a "feeder" corporation, it would not be entitled to exemption under section 501(c)(3) because, of itself, it would not be engaged in the charitable, educational or scientific functions which are the basis for the exemption of its member hospitals.

Why is a federal tax exemption desired? For one reason, it is essential in order to attract grants from charitable foundations and gifts from individuals. Neither would be willing to donate without assurance of tax deductibility or the gift. Secondly, accounting practice sometimes shows income, subject to tax, as a "paper profit" when, for example, loans are amortized more rapidly than the depreciation of the plant or equipment they have financed. And thirdly, without the appropriate federal exemption, in many states the organization would be denied exempt status under state law and would be faced with real estate, sales and income taxes; that is why organizing as a consumers' cooperative is not practical.

The proposed amendment would add a new subsection to the Internal Revenue Code, section 501(c)(18). It would give statutory recognition of the exempt status of joint, group, or cooperative organizations created by nonprofit hospitals, as if the organization's activities were conducted by the member hospitals individually. Personnel of the joint venture also would enjoy the same benefits as accrue to employees of nonprofit hospitals.

In brief, the amendment would encourage hospitals to do collectively some of the activities they now perform individually, but at less cost and greater efficiency than is currently possible. In no way does the amendment reduce the Treasury's actual revenue, either.

The CHAIRMAN. Thank you, Dr. Crosby. Does that complete your Dr. CROSBY. Yes, it does, sir.

The CHAIRMAN. We thank all of you, Mr. Cartmill, Mr. Eppert, Mr. Mueller, Mr. Berke, Dr. Graham, for your statements.

We appreciate having all of you with us and the statements you made. I have just a few questions. I will direct the question to the group. Any one of you who desires to do so may respond. I am sure you have read this HEW Gorham report, have you not?

Dr. CROSBY. I have, sir, yes.

The CHAIRMAN. With respect to that portion of it referring to reasons for acceleration in hospital charges, let me just remind you of what one brief section said:

The acceleration in hospital prices which occurred in 1966 is hardly surprising. Rising wages in tightening labor markets were bound to exert upward pressure on hospital costs. Several nurses' strikes occurred. Preliminary evidence indicates that nurses' salaries increased somewhat faster in 1966 than in previous years.

In the years 1960 to 1965, consumer prices increased at an average annual rate of 1.3 percent while hospital prices increased at 5.8 percent. If this average relationship had been maintained in 1966, the 3.3 percent increase in consumer

prices would have implied a 14.7 percent increase in hospital charges in 1966. In 1966, hospital charges actually increased 16.5 percent which meant that 11 percent of the rise in hospital prices was "unexpected."

The fact that hospital charges rose especially rapidly in the second half of 1966 suggests that medicare, which came into effect July 1, contributed to the increase. Medicare raised hospital occupancy rates in many places. The total occupancy rate was 4 percent higher in August 1966 than in August 1965. In general, however, higher occupancy rates would be expected to lower not raise hospital costs per patient day. The influence of medicare probably came mainly through the impetus it provided to hospitals to reexamine their costs and charges. In the course of reviewing these charges, many hospitals decided to increase them, perhaps sooner than they otherwise would have.

Dr. Crosby, since you have had a chance to go over this matter, what comments do you have on these conclusions of this report?

Dr. CROSBY. I think that the rises in costs have been outlined quite well by not only Mr. Mueller, but also Mr. Berke, where he gave specific examples of a situation which developed essentially on the west coast relating to salaries, wages, for nurses, and this is reflected in the hospital charge. As soon as the hospitals have to increase their pay, their wages, they have to increase their charges.

Our records agree very much with the Gorham report. A recent survey we have had indicates that the room rates, the room rates now, which is about 50 percent of the bill, for semiprivate accommodations throughout the country have increased by 20 percent from January 1966 through March of 1967. This is reflected because of the rising costs in the hospital field.

George, do you want to add anything?

Mr. CARTMILL. No, I think I have nothing else.

The CHAIRMAN. Does anyone else at the table desire to add to that response?

From a preliminary study of the per diem costs that we have been able to make, it does appear that they are running substantially higher than was estimated by actuaries in 1965 when we were trying to determine costs of the plan A part of the program. Do you believe that this represents a faster catching up period than anticipated, or is it more prudent to believe that per diem cost increases will continue in the next few years to run substantially above increases in the earnings level?

Dr. CROSBY. Well, the information which Mr. Berke gave you showed in our studies that for the past 2 years the increase has been at the rate of 30 percent, on an average of 15 percent per year. Now, this is about twice as high as it was the 10 years preceding 1965. We have every reason to feel that this will continue. We don't know for how long this 15 percent per year will continue, if you want to accept the average of these 2 years. I think Mr. Mueller would like to add to that.

Mr. MUELLER. I think one thing that is important to consider is that this increase in cost of care is brought about basically by two factors, one, a very important factor, being the increase in the actual rate of pay to individuals, partly brought about by legislation, partly by the facts that historically many hospital personnel were paid perhaps less than they should have been paid based on market conditions, but it is also brought about by the increasing complexity of medical care, the fact that there are more things being done per patient than were being done years ago.

The number of laboratory tests per patient increased significantly over the years. The number of radiology tests increased significantly, and as a consequence not only are the rates higher, but the complexity of the services are greater, and both of these things combined to cause this increase in cost.

The CHAIRMAN. Well, actually then your estimate of this amount of increase into the future of about 15 percent is about twice what we used for purposes of determining the cost of financing this program. Now, if that is to continue, as you think it might, for as many as 5 years into the future, it raises some doubt about whether or not our original estimates are correct and whether something additional has to be done to finance the program.

Mr. MUELLER. Yes. Mr. Chairman, I don't think that it is possible to prognosticate with any degree of accuracy what will happen.

The CHAIRMAN. There is a point, of course, beyond which the price cannot go because nobody would be able to pay it. That is true. But how long do you see these increases continuing? And I am not quarreling with you. I understand the reasons, I think, for much of the increase. I believe somebody told me one time, representing the American Hospital Association, that a minimum wage applied to your employees meant an additional \$2 billion in payroll per year.

Dr. CROSBY. That is right.

The CHAIRMAN. So we understand that you have some additional costs as a result of a number of things that have happened. What I am concerned about is whether or not we are at this point aware of the fact that we are deficient in financing those costs. That is what I am concerned about. And when I get in executive session, I will have some questions to ask of some other people as to how we could be this far off in estimating those costs.

Mr. MUELLER. I certainly think, and I think the gentlemen at the table would agree, that there has been probably an acceleration over the last 2 or 3 years, a catching-up process which has been moving a little faster with respect to hospital personnel than perhaps the country generally in terms of rates.

The CHAIRMAN. I know, but we are talking in terms of acceleration within a 2-year period resulting in a 30.2 percent increase, which is better than 15 percent a year, and what we are talking about are the per diem increases in hospital costs, are we not?

Mr. MUELLER. That is correct, sir, but in this connection I will just take one specific example. John can help me on this.

The CHAIRMAN. I understand completely. I am not quarreling with the situation. I am merely trying to get information to find out if in your best judgment we need to do something more in the way of financing. I want to know whether you anticipate a continuation of the 15 percent increase in hospital costs for 5 years or 6 years or ten years? We didn't estimate such costs at this level. It is twice as much as we estimated for purposes of fixing a tax.

Now, is this a situation that we can expect for a year or two? Is it a situation that is going on into the future? That is what I am trying to find out, because if it is going on into the future, we might as well face the situation that we haven't provided enough revenue to pay for these costs.

Mr. WILLIAMSON. I think, Mr. Chairman, that in 1962 the average hospital worker was earning about 43 percent less than the average worker in industry.

The CHAIRMAN. I know all of that. I am not deploring what has happened. I am just trying to find out what has happened.

Mr. WILLIAMSON. Our first big increase has been toward catching up with this situation. The minimum wage law now is just taking effect. It started in February.

The CHAIRMAN. That is true.

Mr. WILLIAMSON. This is going to affect hospitals, we projected, with the increases necessary for people covered by the minimum wage and the escalation or the application of that proportion of increase to people who are not covered very substantially, and we are just beginning to see the effect.

As we see the application of the minimum wage law, and the application of the overtime provisions required in this law, which are going to be very costly to hospitals, we see this going on from 3 to 5 years in a very substantial increase.

When you hit 3 to 5 years, somewhere in there it should begin to level off we believe with the rest of the country. We will hit a level when we are comparable and then we should get down to what, are the more normal cost increases year by year which run from 5 to 7 percent.

The CHAIRMAN. But a 3- or 4-year period is your best judgment?

Mr. WILLIAMSON. For 3 or 4 years I think we will look forward to such increases.

The CHAIRMAN. I am not talking about just 2 or 3 years because we tried to finance this program on the basis of estimates of a 25-year period. It looks like the costs in this area are twice as much as we estimated they would be in the first year on which we have any figures. And you think that we may be off that much for another 3 or 4 years and at that time the annual increases probably come down to our estimates. Or will the situation still exceed our estimates in your opinion?

Mr. WILLIAMSON. From what I know of the estimates, Mr. Mills, I think that after this 3 to 4 to 5 years, we will get down to the basis upon which estimates were projected, a more normal level.

The CHAIRMAN. What do you anticipate, Mr. Williamson, will be the total expense per patient day in the hospital at the end of this time, when we get through with these adjustments?

Mr. WILLIAMSON. Well, let's see if I can do it by arithmetic.

The CHAIRMAN. I can take your \$57.93 which is on page nine of Mr. Berke's statement and multiply it myself, but I thought you had already done that. What would it be at the end of this period? I am just trying to see. If you haven't got it, just put it in the record because I think you are going to come out to a rather high figure before you get through.

Mr. WILLIAMSON. This will be upward of \$75.

The CHAIRMAN. That is what I thought. Is that for a single room or a double room?

Mr. WILLIAMSON. That would be an average cost we are talking about now, not room rates.

The CHAIRMAN. So a single room would be higher than that?

Mr. WILLIAMSON. Pardon?

The CHAIRMAN. A single room would be higher than that.

Mr. WILLIAMSON. No.

The CHAIRMAN. What do you mean by average cost?

Mr. BERKE. Mr. Chairman, the \$75 that we are talking about now represents the total average cost for the patient for a day. This includes the room, board, the nursing, the operating room, and so on. Of that total cost approximately 50 percent is reflected in the room rates. So about \$40 for a semiprivate room, I would say.

The CHAIRMAN. I understood we were talking about the total cost. I understood that. But in that total cost when you say "average" you would make some allowance, wouldn't you, as to whether or not a person had a single room or a double room or whether he was staying in a ward.

Mr. WILLIAMSON. You are talking about charges versus costs and we were talking about costs.

The CHAIRMAN. That is right.

Mr. FREITAG. Mr. Chairman, I think one facet in projecting over into the future on hospital costs has to be the consideration of what is happening with the availability of nurses. There is a severe shortage of nurses in the United States. Thirty-five percent of the salary costs approximately, in my experience of hospital costs, go to nursing personnel. I think you are in the situation of the bidding up of these costs as between hospitals in order to get the personnel they need. This also may have an effect on your future projections which would take them beyond what has been projected on a normal basis.

The CHAIRMAN. Have I not asked enough questions to get you to agree with me that we may be in need of additional financing of this program over and above what we have already levied?

Mr. EPPERT. Yes.

Mr. WILLIAMSON. If the kinds of things we spelled out weren't fully anticipated in the program, then you will be in for very substantial increases in the cost.

The CHAIRMAN. People come up here with a miscalculation on the cash benefit side and tell us that that is because they overestimated the length of time that people would live on down into the future and how many children they would have and so on. Now we have an underestimate here.

In balance, some of that which we levied for cash benefits may be needed for this purpose. Is that what you are saying, or that we have to increase this particular tax for this specific purpose, one way or the other?

Mr. WILLIAMSON. One way or the other you are going to have to do it. We thought this would be a specific tax and would be funded as such.

The CHAIRMAN. It is funded that way, but now the total of this tax goes to what finally? Is it 1.6 in combination? Is that what we levied?

Mr. WILLIAMSON. Yes.

The CHAIRMAN. That is right. As you look at this thing, have you had any actuaries make any estimate for you with respect to what

the total of that tax on employer and employee might have to be finally?

Mr. WILLIAMSON. No, we haven't.

The CHAIRMAN. I mean within this 25-year period. That is all we ever talked about, a 25-year period.

Mr. WILLIAMSON. No, we haven't.

The CHAIRMAN. We finance the cash benefits on actuarial estimates over a 75-year period, but this program, over a 25-year period, and here in the very inception costs are increasing twice as fast as we had originally estimated. I don't know. I am a little bit disturbed.

Mr. BYRNES. Of course, Mr. Chairman, Mr. Cartmill did suggest that the Government has an obligation to fully finance the existing program before undertaking additional obligations. It would be better to consider some of the recommended additions in conjunction with what we have.

The CHAIRMAN. I am talking about the existing program right now. I am trying to find out just what it takes to finance it.

Mr. BYRNES. Right.

The CHAIRMAN. Let me go to another matter.

The law states in substance that hospitals should be reimbursed for actual cost of care incurred for the aged beneficiaries. Is that your understanding of the law?

Mr. CARTMILL. Yes, sir.

The CHAIRMAN. All right. However, it turns out that costs of the aged more closely approximate the average per diem cost and again the actuaries' cost estimates will be somewhat off because we assumed a lower cost for the aged than the rest of the population. Is it your position that the HEW formula is more designed to protect the cost estimate rather than to really ascertain the cost of aged beneficiaries? You can take the fifth amendment if you want to.

Mr. MUELLER. Mr. Chairman, if I might field that particular question, I must start by saying I can't judge what the Social Security Administration had in mind when they promulgated the regulation. I can only refer to the effect of these regulations.

The CHAIRMAN. It is not just regulations; it is the law setting up the financing of it that I am talking about, as well.

Mr. MUELLER. Very good, sir. I then can't go to the reason.

The CHAIRMAN. The actuarial estimates that caused us to finance the program the way we did.

Mr. MUELLER. Well, the studies which are available to us today based on the work that has been done indicate that the average cost of medical and surgical care more closely approximates the cost of caring for the aged than does the cost arrived at through the application of the RCC formula.

On the other hand, studies that are available indicate that even this does not equal the cost of caring for the aged; in other words, that the cost of caring for the aged is even greater than the average cost.

The CHAIRMAN. Is that the per diem cost?

Mr. MUELLER. Yes, sir, per day.

The CHAIRMAN. When you say the average cost.

Mr. MUELLER. Yes, sir.

The CHAIRMAN. That is what I am talking about. All right. If you are right—and my asking you the question indicated I thought

there might be some basis for your being right—if then we find that the cost of taking care of our aged more closely approximates the average per diem cost, what is the difference in the cost for purposes of financing this program, do you know?

Mr. MUELLER. You mean the expanded effect of these increases in cost on the tax?

The CHAIRMAN. How much additional cost will there be in taking care of our aged people for whom we made the commitment in this program if the cost of taking care of them is not what we estimated, but approximates your average per diem cost? We are not allowing you per diem cost in our estimates. We haven't financed in this program on the basis of per diem cost.

What I am trying to find out is if it does actually cost more for these people, as your average per diem cost indicates, then how much have we underestimated such cost?

Mr. STAGL. If I understand your question, Mr. Chairman, in some meetings I was told or am under the impression that in estimating the cost of the program they reduced from average cost, I think, 7 percent. Is that correct, Kenney?

Mr. WILLIAMSON. Yes.

The CHAIRMAN. Maybe I am wrong, but I thought it was 13 percent.

Mr. STAGL. Whatever that figure of reduction was, if it now turns out that the cost for the aged patient is indeed the same as every other patient or more, then it is that figure that will be additional cost, 7 percent, 13 percent, whatever it is.

The CHAIRMAN. It is just that figure, just that simple?

Mr. STAGL. That would be all I would think, yes.

The CHAIRMAN. Then is there any way of judging on the basis of this partial year of operation of the program that the costs may really be higher for the aged than the average per diem cost? What is the situation as best you understand it?

Mr. BERKE. It is awfully hard to tell that. There have been some studies made on services for hospitals in California which indicate that the nursing care for patients 65 and over exceed the nursing care for patients under 65 by approximately 20 to 30 percent.

There is a national study being made by the American Hospital Association which is not yet concluded but which indicates roughly the same thing. I don't think we have any actual cost figures broken down to show what the cost of the average aged is compared to those younger, but at least this is an indication of the additional cost to us of the care of these people.

The CHAIRMAN. Does anyone else care to say anything on that?

Let me go to another matter then.

In our discussion of reimbursing hospitals, aren't we really looking for a method which will actually and accurately reflect any differences between the cost of the aged and those under 65? Mr. Mueller?

Mr. MUELLER. I would think that would be a very desirable objective if it could be achieved, yes, sir.

The CHAIRMAN. I think that is the way we started out to do it, on the basis of what we were told at the time.

Mr. BYRNES. Did we do it, though, on the basis that, in order to tell the cost of the program as being with reason, HEW estimated that the charge for the over-65 would be less than the average?

The CHAIRMAN. Oh, absolutely, we were told that, whatever the reason was.

Mr. Mueller, I understand that you questioned the HEW method of allocating costs because that method doesn't fully reflect certain costs.

As an example, it probably doesn't reflect all of the costs of nursing. Is that right?

Mr. MUELLER. That is correct, sir. That would be the effect of it.

The CHAIRMAN. And as this witness said, these actual costs with respect to nurses may be higher for the aged than for those under 65. Now let's get this down if we may. Other than what has been said concerning these studies and these analyses in California, do we have other evidence that this may ultimately be the situation? Is there anything else that we could point to indicating that other factors may be higher?

Mr. WILLIAMSON. One major area, Mr. Mills, that we pointed out in the past in our discussions with the social security people is our feeling or questioning seriously as to whether they fully estimated what would be the costs in extended care facilities. They were pricing the care ultimately, we felt, for the sort of care to be provided at much less than we would on the basis of what we thought were likely costs.

The CHAIRMAN. I think you told us that at the time.

Mr. WILLIAMSON. We told you that at the time; yes.

Another area we questioned—that has to be proven—was we thought they were must too optimistic as to the financial effect of outpatient services, that this would greatly reduce the volume of inpatient care, and we warned that there were many examples that this doesn't happen. That good, thorough diagnosis on an outpatient basis often increases inpatient care because it proves the need for the care. So we questioned whether they were evaluating such matters the way we would as health professionals.

The CHAIRMAN. Will this 2-percent allowance over what we thought the costs were going to be compensate for these changes that you already know about?

Mr. MUELLER. I don't think there is any question but that it will not compensate for these factors that we have been discussing.

The CHAIRMAN. I am not shaking my head in doubt. Would you supply for the committee a table, if you can get it together, showing the amount of daily costs used for this medicare purpose compared with the daily rates on which the Blue Cross is paying you?

Dr. CROSBY. Yes, sir.

The CHAIRMAN. This program reimburses on a cost basis. I understand Blue Cross pays you on what? Charges in most instances?

Mr. WILLIAMSON. On a per diem. There are various methods, involving costs and charges.

The CHAIRMAN. Anyway, what I would like is a fair picture of the rates Blue Cross is paying for a day of care as compared to what medicare is paying, together with an explanation, if you can think of one or develop one, of the differences in the rates.

Mr. WILLIAMSON. Yes, sir.

The CHAIRMAN. Will you do that for me, Mr. Williamson?

Mr. WILLIAMSON. Yes.

Mr. BYRNES. May I ask if they would do this in regard to payments they receive from other carriers?

The CHAIRMAN. Yes.

Mr. BYRNES. Because Blue Cross operates on a bargaining basis and on a community basis. That is sometimes distorted from the basic cost, isn't it?

Mr. WILLIAMSON. You want a comparison to show what payments received from the Federal Government for medicare are as compared with payments received from Blue Cross and payments received from noninsurance patients, say?

The CHAIRMAN. Payments for the hospitals, yes.

Mr. BYRNES. Well, or other carriers.

Mr. WILLIAMSON. Or other carriers.

Mr. BYRNES. Other third parties.

Mr. FREITAG. With regard to the other carriers, you have to be careful because you get all kinds of policies that are written for hospital coverage. Some of them do not cover full costs or full billing rates, so the comparison may be not so good.

The CHAIRMAN. That is the reason I picked Blue Cross. I thought it would probably give us a better comparison than some of the others.

Mr. WILLIAMSON. We will get you all we can, anyway.

The CHAIRMAN. Give us all you can on it.

Mr. BYRNES. You are saying that these other carriers have a co-insurance factor, but the payment is based on 100 percent of the charge.

Mr. FREITAG. Yes.

Mr. BYRNES. I don't know that that creates much of a problem in getting the figures of the amounts paid.

The CHAIRMAN. You can do that?

Mr. WILLIAMSON. Yes. (See p. 751.)

The CHAIRMAN. All right. Include that if you will.

Mr. BYRNES. In most cases.

The CHAIRMAN. It is my understanding that HEW argues that where a State like New York has a State medical facilities planning agency, hospitals under medicare should be required to comply with the State regulations.

Is this a sound position or not?

Mr. CARTMILL. I think our position, Mr. Chairman, is that we feel it is sound to a point, and I think Dr. Graham will probably want to enlarge on that because he is from New York. We have taken the position, as you know, this morning that for capital expansion, increase in plant and so on, we believe in doing this in conformity with sound community planning, which we think is possible on a voluntary basis, but that for those elements of depreciation or whatever, needed simply to replace or to develop within the sphere of present operation we do not think that this necessarily should be put on the table for a statewide agency to approve.

Have I hit the question, sir?

The Chairman. Yes, Dr. Graham, do you want to add to that?

Dr. GRAHAM. Mr. Chairman, we have now lived under this program for almost a year, in New York. We find some inequities in it as far as the hospitals' ability to improve their services, but in general we

feel as those of us would have the opportunity to become involved intimately in the planning agency from the State level down to the regional level good things are coming to the planning of hospitals and health facilities in those regions, and personally I feel that as time goes it will become a good system for our health facilities in the State of New York.

The CHAIRMAN. Thank you. I am not certain whether you had access to the statement made by Mr. McNerney. Anyway, Mr. McNerney stated that as new equipment is placed in hospitals there is not only an increased cost for the equipment, but also increased costs because the ratio of employees to patients goes up.

Do you agree with his analysis of that situation?

Mr. WILLIAMSON. Yes, generally the ratio has gone up.

The CHAIRMAN. This then is one of the factors that we can look to in the future as increasing the cost for hospital care; is that right?

Mr. WILLIAMSON. Yes.

The CHAIRMAN. I don't know what we could do about that even at the last session.

Mr. CARTMILL. Mr. Chairman, if I understand Mr. McNerney's statement, which I did not see prior to this time, I don't think this necessarily follows in a hundred percent of the cases. If by placement of new equipment he has reference to equipment needed in new services, advanced technology, and so on; which then takes people to run—let's take the coronary care unit, for example, wherein there is much in the way of new equipment which needs new and well-trained personnel to run—he is quite right.

There are, on the other hand, in some instances I think new equipment which added to something at least in the realm of mechanization rather than human hands, so that I think what I am trying to say is that new equipment in the hospital field I think is looked at in much the same way as it is in industry. We hope by the addition of this technology to save in that realm which forms the greater part of our hospital cost.

On the other hand, in attempting to reach the ultimate in good medical care, obviously there is much in the way of new equipment which also requires new people to go along with it.

The CHAIRMAN. I know, but I viewed this as a little different situation from Mr. Eppert's operation as chairman of the board of a business that can automate without having the result that I thought Mr. McNerney was talking about the other day that occurs in hospitals as they add additional equipment.

In industry the addition of certain equipment may reduce materially certain labor costs, but I don't believe we have gotten to the point yet where we want to go to an automated hospital and I don't believe you are going to develop that very quickly.

Mr. CARTMILL. No, sir; in that context you are perfectly right, as is Mr. McNerney.

The CHAIRMAN. As you do add additional equipment your labor costs will go up, even though you do have some savings in some areas, but on the whole they will go up, is that right?

Mr. CARTMILL. I would agree, yes, sir.

The CHAIRMAN. That is what I was getting at.

Let me ask you about your bad debts. You know, we were told that if everybody had his hospital bill paid in some way you wouldn't have any bad debts.

Now, are you having less problems with bad debts and the need to give charity since the beginning of medicare or not?

Mr. MUELLER. Sir, you asked a couple of questions and I will try to answer them, if I may.

The CHAIRMAN. Yes. I may have had three in there.

Mr. MUELLER. To answer the last one first, we have continued to have bad debts and have continued to have free care since the passage of the legislation you referred to.

The CHAIRMAN. I am talking about those 65 having bad debts.

Mr. MUELLER. I would say not of course those that are covered.

On the other hand, there are limitations on the coverage and to the extent that the people were not covered by reason of the length of their hospitalization or otherwise, then of course you would have bad debts with respect to these people.

In terms of the free care side of the thing, yes, there are significant amounts of free care rendered to persons who would normally, you would think, be covered by title XIX, people who do not meet the means test as prescribed within the particular State, but yet who must have hospitalization and who cannot pay for that hospitalization.

Mr. EPPERT. Mr. Chairman, may I add just one point on bad debts?

The CHAIRMAN. Yes, sir.

Mr. EPPERT. A bad debt isn't one that is necessarily never paid, but a bad debt can impose an added cost or loss, so to speak, because of the time of payment.

In other words, delinquencies are really bad debts in a sense, and the time element of reimbursement I think is an important factor insofar as working capital requirements are concerned; in other words, the turnover of the payments.

Aside from the uncollectable.

The CHAIRMAN. Yes, Dr. Graham.

Dr. GRAHAM. Mr. Chairman, in my testimony you may recall that my controller had written a letter to an intermediary, but the two of us have sat down for many an hour discussing what to do with these small portions of the outpatient diagnostic benefits, and we have come almost to the point just to label those as bad debts because the 16 cents or 6-cent bill really is not worth the money required to bill the patient for it, so I suppose in a sense we are inheriting bad debts which in good accounting should be just that because we put good money after bad, if I may put it that way.

The CHAIRMAN. Mr. McNerney also testified when he was here that he had some experience which shows that the hospital utilization rates of the population under 65, both the proportion of people who go to the hospital and the length of their stay in the hospital, has gone down between 1965 and 1966.

Do any of you have any knowledge of this, or is this your experience?

Dr. CROSBY. In Mr. Berke's testimony—

The CHAIRMAN. I must apologize because I missed a whole lot of what you said and I notice on page 10 of Mr. Berke's testimony that

there was some indication in this area. Bring me up to date, will you, on what was said at that point?

Mr. WILLIAMSON. Page 10.

The CHAIRMAN. Apparently your experience is the reverse, as I look at these tables of what Mr. McNerney said his experience was.

Dr. CROSBY. The average length of stay of people under 65 I would say remained about the same, although in July it was 7.8 and 6.8 in December, but the average length of stay for the over-65 has gone up from 11.2 in the month of July and creeping up and the figure for December is 13.3.

Now, the admission rates for people 65 and over I think is about stabilized at about 19 percent if you look at July and December.

The CHAIRMAN. Wait a minute. I misread your table here. In July the average length of stay in number of days for those under 65 was 7.8.

Dr. CROSBY. Yes.

The CHAIRMAN. And it has dropped down in December to 6.8.

Dr. CROSBY. 6.8, yes. If you look at the other ones it looks just about 6.8, August, September, October, November, December.

The CHAIRMAN. That isn't enough information really to know what the answer to the problem is?

Dr. CROSBY. No.

The CHAIRMAN. I see. Mr. Mueller, I heard most of your statement. On page 3, as I recall, of your statement you referred to the regulations on special-purpose donations.

Mr. MUELLER. Yes, sir.

The CHAIRMAN. My inquiry is stimulated by your comment. However, I have some hasty recollection that the American Hospital Association had taken some position with respect to this very point. Had it, Mr. Williamson?

Mr. WILLIAMSON. No. No, I don't think so. Our position is as outlined by Mr. Mueller.

The CHAIRMAN. I thought you had a—

Mr. MUELLER. I think I could probably clarify that if I may try to.

The CHAIRMAN. All right.

Mr. MUELLER. I believe that it is the position of the American Hospital Association and most people in this field that to the extent that a donor makes a gift to a hospital for the purpose of defraying a certain type of cost and he knowledgeably wishes to defray that cost, you should then not also be reimbursed for the cost from a third party.

The point we are making here is that the people who donated this money had no knowledge of the fact that this cost was going to be assumed by the Government and that therefore it could obviously not be considered to be their intent to have made this money available to the Government.

The CHAIRMAN. Well, this doesn't represent change in the position of the American Hospital Association then with respect to this matter.

Mr. MUELLER. No, sir, it does not.

The CHAIRMAN. I thought on the basis of what I had read from your August 1965 edition of the American Hospital Association Principles of Reimbursement it represented some change in viewpoint. If it did I wanted you to tell me.

Mr. WILLIAMSON. No.

The CHAIRMAN. Mr. Mueller, is it not true that the American Hospital Association principles did state that depreciation should be based upon historical cost?

Mr. MUELLER. Well, sir, the statement of principles with which I am familiar and which would be presently outstanding ones do not state that, no, sir.

The CHAIRMAN. What I am trying to ascertain is whether or not there has been any change in your position on this particular point.

Mr. MUELLER. Well, sir, the only statement of position which I am aware of is the one which was issued in February 1966.

The CHAIRMAN. I wasn't criticizing anybody for changing his position, you understand. I just want to know whether or not there has been any change.

Mr. MUELLER. I can say no, as far as I know the position of the American Hospital Association is not that depreciation must be based on historical cost, but rather that it must be based on the value of the dollar.

The CHAIRMAN. All right then. Is that the principle that you apply across the board for depreciation purposes for those cases paid for by the Government and those cases paid for by Blue Cross, or by insurance companies, or by individual payments? Would you apply the same rule in every case?

Mr. MUELLER. If I may answer that this way, this is the position of the American Hospital Association as indicated in the policy documents they have issued and as reflected in the accounting manual which was issued by the American Hospital Association and is in general circulation. The extent to which this was accomplished with respect to any particular Blue Cross plan must of course depend on the particular terms of the plan. I can refer you, for example, though, and this is very important, to the Illinois plan. The Illinois plan does not state that they will allow depreciation on a price level basis, but it does say they will allow depreciation based on 6 percent of total operating costs and then in addition will pay the hospital 5 percent of total operating costs over and above that factor, so that the large depreciation allowance plus the 5 percent additional allowance does in fact cover the economic value of the facility used up under that plan.

Other plans have differing provisions.

The CHAIRMAN. I don't want somebody to say to us when we get in executive session that what you are advocating is a method of basing depreciation for purposes of charging the Government that is different from the method which you would use in charging anybody else. That is what I am trying to get to.

Mr. MUELLER. Mr. Mills, we couldn't agree more and, as a matter of fact, I believe our formal testimony indicates that we believe the Government should only pay as much as other patients are paying, not any more.

The CHAIRMAN. That is right. You want to be certain that you get all your costs for taking care for these people. That is what you want?

Mr. MUELLER. Yes, sir.

The CHAIRMAN. But I don't want somebody telling us later on that you are using some different methods for determining those costs to

the Government from what you use in determining costs to somebody else.

Mr. MUELLER. Right. We believe the same principles are applicable.

The CHAIRMAN. And the answer to that is that you do not?

Mr. MUELLER. That is correct, sir, although the exact formulas will vary considerably.

The CHAIRMAN. Oh, I understand, yes. Has the American Hospital Association taken the position which Blue Cross has taken that depreciation costs should be based upon replacement value? Have you taken any position like that?

Mr. WILLIAMSON. Yes. This position was adopted officially in August 1965.

Dr. CROSBY. Yes, sir. That is in our principles of payment.

The CHAIRMAN. I thought I understood that. These earmarked gifts then should be included in what Blue Cross pays for its subscribers; or should they not?

Mr. MUELLER. As to whether they should be or not, the principles would certainly be as outlined here.

The CHAIRMAN. You have asked that they not be considered for purposes of Government cost? Is that not what you are saying?

Mr. MUELLER. Yes, sir, they should not be deducted for the purpose of determining cost.

The CHAIRMAN. Should they then be considered for purposes of Blue Cross costs?

Mr. MUELLER. Certainly not. The same principle should apply.

The CHAIRMAN. What would you use these principles for? Charity cases?

Mr. MUELLER. There are many examples in case of endowment funds. You may receive an endowment by a gentleman who died in 1910 that will be used to defray the salary of the head of a department of medicine, for example.

The CHAIRMAN. Nobody in particular gets the benefit out of his services. They would all get the benefit of having him there.

Mr. MUELLER. That is right, and we are saying that the people who utilize his services should then pay for his cost.

The CHAIRMAN. I am not certain I understand just how you handle it, but I don't want to take the time of the committee. Give me something I can have, if you will, for the record at this point showing just how for these purposes and for Blue Cross purposes or any other payment purposes these endowments and donations would be treated if you had your way.

Mr. MUELLER. Sir, I would say that either legislation or regulation should be promulgated, whichever would be necessary to accomplish those I described which would say in effect, (a) that any special-purpose donations which were given to the hospital prior to the enactment of the legislation would not be used as offsets or reductions of reasonable cost. I would say point (b) that any special-purpose donations rendered that were given after the enactment of the law could be deducted from operating cost unless so specified to the contrary by the donors.

The CHAIRMAN. Let me ask you this. Maybe it is because I don't understand exactly how it operates today. I don't know whether I

can develop a case in point as to what is done in determining reasonable cost in the treatment of these balances.

Say that without consideration of any amount of money the reasonable cost per day of taking care of one of these patients would be \$50. Do they then say that we will only pay you \$48 because you have sufficient endowment to reduce the cost of each patient's care by \$2?

Mr. MUELLER. That is precisely correct; yes, sir.

The CHAIRMAN. That is what they are saying.

Mr. MUELLER. Yes, sir; and that is what is specified in principle 1-6 of the regulations.

The CHAIRMAN. That isn't payment then to the cost of that particular patient by Federal funds?

Mr. MUELLER. That is right. They are using the income to reduce the overall cost of operating the hospital.

The CHAIRMAN. You mean you are willing to settle on the basis of any endowments made previous to the enactment of this program, but anything that comes in after the enactment can be deducted.

Mr. MUELLER. Sir, the practical fact of the matter is that I question seriously whether anything since the date of the enactment would be donated on a special-purpose basis. I think it would be an excellent aid in helping hospitals to be able to raise moneys of this type if all special-purpose donations were excluded.

On the other hand, if I do not choose to approve current donations it won't affect the reimbursement under the act because I do not think people will give money on this basis with that type of regulation.

The CHAIRMAN. But we do want them to continue to make special donations and endowments.

Mr. MUELLER. I think it would be very desirable. If I may give one example, and this again is a matter of regulation not law, I understand from reading one of the recent interpretations that have come out of one of the Blue Cross plans that a produce merchant who wished to donate some produce in kind, potatoes or cabbage, whatever it might have been, to the hospital did so but it was stipulated that this particular produce would have to be treated as a special-purpose donation and, therefore, the effect of giving the produce was that he gave 30 percent of it to the medicare plan.

It is my contention that even when special-purpose donations of this type are given they should be given for the use of the hospital as a whole and should not be used to offset reasonable cost.

The CHAIRMAN. Let me go to this matter of the guide issue that was put out by your organization last August in which you said that nonprofit hospitals had total revenues exceeding patient care costs by 4 percent.

Do you have any information today as to how this percentage has been affected by the medicare program?

Dr. CROSBY. I would say we don't have any real information on that, Mr. Chairman.

The CHAIRMAN. How soon can you have it?

Dr. CROSBY. We think May, according to the studies we are doing now. (See p. 751.)

The CHAIRMAN. May?

Dr. CROSBY. May.

The CHAIRMAN. Can't you get two more people to study it and get it in before then?

I think it is important. I think it has a direct bearing on——

Dr. CROSBY. One of the problems of course——

The CHAIRMAN. What we do here.

Dr. CROSBY. Is that there has been no closing of any of the hospitals yet, even the ones that closed on September 30. There have been no closings so we just don't know what the effect is.

The CHAIRMAN. For the purpose of this record define what you mean by closing.

Dr. CROSBY. The closing of their books.

The CHAIRMAN. That is what I thought. I wanted to distinguish. I don't want people who read the record later to think we were talking about cessation of operations.

Mr. Cartmill, on page 11 of your statement, which I did get to hear, what do you mean when you say :

We hope that the basic improvements made by the Congress will not be removed in the amendments now being proposed for the program.

Mr. CARTMILL. I am sorry. It is page what?

The CHAIRMAN. Page 11. It is with respect to title 19. It is on page 11 of this mimeograph that I have before me. It is in the first partial paragraph on that page. You say:

Therefore, this program is of very great importance to hospitals. We feel the Congress made some very important changes in respect to the provisions of health services to needy persons, and we supported them. We hope that the basic improvements made by the Congress will not be removed in the amendments now being proposed for the program.

What do you mean?

Mr. CARTMILL. The general scope of the amendments now being proposed I think lies——

The CHAIRMAN. You mean to say that you don't want us to cut back any of the Federal participation under title 19?

Mr. CARTMILL. No, I wouldn't say that, sir, but I think whatever may be the necessity to cut back, the basic components of the support of this category of patient will not be seriously jeopardized.

The CHAIRMAN. You mean that we maintain support at whatever levels we finally decide for those people who are presently encompassed within the program? Is that what you are saying?

Mr. CARTMILL. Yes, sir.

The CHAIRMAN. Fine. I just wanted to be certain. I appreciate very much your responses to my questions. I know there are other questions. Mr. Byrnes.

Mr. BYRNES. Your testimony put considerable emphasis on the problems related to the RCC method. Has that method been carried over into title 19 also?

Mr. MUELLER. I am not knowledgeable on that.

Mr. WILLIAMSON. No, it hasn't. Not yet.

Mr. BYRNES. I got the impression though, that you thought it might be applied under title 19. Since the patients over 65 are segregated for purposes of applying the RCC method, the same procedure might be followed for children and other patients under 65.

Is that what you are concerned about?

Mr. WILLIAMSON. That is right; yes, sir.

Mr. BYRNES. If we extend coverage to the disabled on the same basis a new cost accounting would have to be developed in order to apply the RCC method, to the various categories of disabled patients. Their problems, according to testimony we received the other day, may be different from the general problem of those over 65.

Dr. CROSBY. That is correct, Mr. Byrnes. What we have felt from the very beginning and talked to the Administration about is that whatever method you use for one group of patients you have to use for the other, so we say that you should use average per diem throughout the title 18, title 19, the disabled and so forth.

Mr. BYRNES. That is what I was thinking. If we do adopt your proposal for using the average per diem basis, we would also eliminate difficulties that you foresee in the future in connection with title 19 cases—aid to dependent children, aid to the blind, and so forth.

Dr. CROSBY. That is right.

Mr. BYRNES. We would also avoid the problem that we will be confronted with if we cover the disabled under the same regulations that are now in existence for the over 65.

Dr. CROSBY. That is right, sir.

Mr. BYRNES. If we moved to that you would avoid some of the definitional problems involved in the phrase "reasonable cost." You automatically get rid of that big area you referred to as needing redefining.

Mr. MUELLER. Yes, sir, this would be one of the things that would be helpful in that connection. It wouldn't eliminate the other problems, but it would be helpful.

Mr. BYRNES. Thank you.

Mr. FREITAG. Mr. Byrnes, may I comment briefly on what you said about RCC? I think you should be aware of the practicalities of the situation of applying RCC. I believe my figures are reasonably correct that there are approximately 2,900 hospitals in the United States that are under 100 beds. This same application of this very complicated formula has been made to these hospitals as has been made to the large hospitals.

The additional costs incurred in just keeping these records is fantastic. Many of them do not have qualified people within their walls to do this. We have to hire outside help at additional cost. The additional costs of auditing as is required under the act will be substantial under RCC as compared with what they would have been under an average cost.

I think all of these things should be taken into consideration in these judgments.

Mr. BYRNES. I understand the serious complications that are involved in the RCC method, and I think you have made a very good case. Of course during all the original proceedings on medicare in 1965 I expressed the fear we would have trouble if we made the cost the basis of payment. It seemed to me that something like reasonable charge would be a better way of proceeding. That is the definition used for reimbursing the physician.

I never could understand why the Government insisted on cost accounting every penny it paid to hospitals. That is what we are now

doing and what is causing the problems. You won't know how serious your problems are until some audits are performed after the closing of the hospital's books. You haven't reached that stage yet, have you?

Mr. WILLIAMSON. No, sir.

Mr. MUELLER. No, sir.

Mr. BYRNES. You have a little work coming along then, haven't you?

Mr. MUELLER. Yes, sir. We will be quite active in the next year or so.

Mr. BYRNES. That is all, Mr. Chairman.

The CHAIRMAN. Any further questions?

Mr. SCHNEEBELI. Mr. Chairman.

The CHAIRMAN. Mr. Schneebeli.

Mr. SCHNEEBELI. I would just like to note that I am very appreciative of this fine presentation and I think it is one of the most professional jobs I have ever heard. The coverage I think has been most complete and adequate and I thank the American Hospital Association for the excellent information given to our committee.

The CHAIRMAN. Mrs. Griffiths.

Mrs. GRIFFITHS. I would like to add my appreciation too. I think you have made a good and compelling case for your side of the argument and I am very interested in listening to Social Security defend themselves.

Is there any cost connected with internal thefts within a hospital? Do you have a cost set up for this? Is it increasing, decreasing, or what?

The CHAIRMAN. Thefts by persons. Is that it?

Mrs. GRIFFITHS. Yes. Let me give an example. A young woman who is a dietitian went to work one morning at 5 o'clock in the best hospital in my district. She counted the incoming filets. There were 400 at \$2 a steak. When she left the hospital she went back and recounted them. There were four left. She then checked the orders and there were only four. Three hundred and ninety-two steaks disappeared at \$2 a steak.

Mr. MUELLER. Mrs. Griffiths, I think, if I may comment on that just for a moment, that probably the incidence of employee and other pilferage in hospitals is probably no greater, no less, than it is in any other of our institutions and the temptations that apply to hospital personnel apply similarly in other aspects of our industry. I don't have any figures on it, but I am certain that things such as you indicate do happen. We try to place controls over them to assure ourselves that they do not happen to any great extent.

Mrs. GRIFFITHS. You don't know if it is going up or down?

Mr. MUELLER. I haven't the faintest idea.

The CHAIRMAN. Any further questions of these very fine witnesses? If not, gentlemen, I want to thank you too for your presentation. You did an excellent job.

Mr. EPPERT. Mr. Chairman.

The CHAIRMAN. Yes, Mr. Eppert.

Mr. EPPERT. We have a figure that was developed yesterday that you might like to have on this discussion of depreciation on a replace-

ment basis. In the nonprofit hospitals there are in excess of a half million beds, but just using a round figure of 500,000 beds, the replacement cost per bed today is right at \$30,000.

The CHAIRMAN. What was it 3 or 4 years ago?

Mr. EPPERT. We had that figure.

Mr. WILLIAMSON. \$25,000, 4 years ago.

Mr. EPPERT. And 10 years ago it was much less than that.

Mr. WILLIAMSON. \$18,000 to \$20,000.

Mr. EPPERT. The point is in the nonprofit hospitals today the total assets in plant and equipment, which is what we are talking about, and depreciation, is \$9 billion. If you multiply 30,000 times 500,000 beds you come out with \$15 billion, so on a straight line depreciation basis, on the basis of present cost of replacement, we are 40 percent deficient in our depreciation cash flow so far as replacement is concerned.

The CHAIRMAN. Thank you very much for that additional information. Again we thank you gentlemen for coming to the committee and being as helpful with this problem as you have. You have been most helpful. Thank you very much.

Mr. CARTMILL. Mr. Chairman, we thank you, sir.

The CHAIRMAN. Mr. Broyhill.

Mr. BROYHILL. Mr. Chairman, testimony by American Hospital Association witnesses and others before the committee indicates that spiraling health care costs—particularly hospitalization—is threatening the already precarious financing of the present medicare program. These rising costs make it certain that we are going to be faced with the difficult decision of raising additional taxes to finance benefits already on the books or of diverting revenues from the cash benefit trust fund to the medicare trust fund.

We have been told that (1) the cost of hospital care across the Nation is expected to average almost \$58 a day by September and to level off at \$75 in 3 to 5 years; (2) medicare patients are staying in hospitals longer than the previous average stay by an aged person; and (3) hospitals are being forced to charge other patients for part of the hospital service the Federal Government requires without adequate payment for its medicare patients.

I want to make it abundantly clear that I am not opposing the providing of adequate medical care for our senior citizens. All of us should be interested in doing everything we possibly can to improve their situation. But the question was when we originally considered medicare, and the question remains with us today, whether or not the medicare approach was the most efficient and equitable way of financing the system making certain that abuse and waste is prevented.

Mr. Chairman, it is a cause of genuine concern that the medicare program, which has now been in operation for less than a year, should already prove to be underfinanced; it is a cause of genuine concern that our cost estimates made as recently as 2 years ago for a program intended to endure in perpetuity have proved to be sharply short of the mark.

This shocking disclosure of gross error in estimating costs for the few months the medicare program has been in effect places a disturbing shadow of doubt on the administration's current financing pro-

posals for the new and expanded benefits now being studied by the Congress.

While the realization of error in estimating medicare costs comes as a disappointment to all of us, it was clearly foreseeable 2 years ago that health costs would spiral under medicare and we would be threatened with the very problem we face today.

In the separate views I filed in the committee report in March 1965, I pointed out that inclusion of service benefits under social security would jeopardize the soundness of the program, that the program would prove to be underfinanced, and that these defects would be aggravated by the certain expansion of the program once it was started. At that time I predicted we would wind up robbing one trust fund to provide temporary solvency to another. It was for this reason that I and a number of our colleagues sponsored the so-called eldercare proposal so as not to jeopardize the solvency of the system.

I assume we can depend on a painless way proposal from the administration to relieve this underfinancing problem, by diverting funds from the cash benefit trust account to the health care trust fund. A similar device was followed in 1965 to rescue the disability trust fund from insolvency, but I warn against continuing this practice. A day of reckoning must come.

Mr. Chairman, as part of my remarks I would like to include in the record of this hearing excerpts from the separate views I filed in the committee report in March 1965:

EXCERPTS FROM ADDITIONAL SEPARATE VIEWS OF REPRESENTATIVE JOEL T. BROYHILL, PAGES 258-264, HOUSE REPORT NO. 213, MARCH 29, 1965, 89TH CONGRESS

"...

"(4) Medicare would for the first time inject into our OASDI system *service* benefits as distinguished from predeterminable *cash* benefits with the consequence that unpredictable costs and overutilization would jeopardize the soundness and acceptability of the social security program as well as necessitate a vast and costly expansion of health care facilities.

"(5) The Consensus of nongovernmental actuaries experienced in health insurance matters hold that the medicare program is under-financed; . . .

"(6) The economic thrust of the higher employment taxes . . . problem would be further aggravated by the certain expansion of the program once started."

"...

"(4) The eldercare proposal would neither interfere with nor endanger the established concept of confining OASDI benefits to cash payments and would avoid the risky adventure of service benefits—an adventure that is failing in virtually every other major country.

"(5) The eldercare proposal would not require the imposition of higher regressive payroll taxes and it would not jeopardize the actuarial status of the present OASI system."

(The following material was received by the committee:)

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., April 13, 1967.

HON. WILBUR D. MILLS,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, D.C.

DEAR MR. MILLS: In accordance with your request of March 8, 1967 upon the occasion of our appearance before the Committee on the bill H.R. 5710 there is attached as Item A a summary presenting the various methods used by the Blue Cross plans to recognize financial needs for hospitals. This summary is a result of a survey made in 1964 by the Blue Cross Association of reimbursement methods of Blue Cross plans up-dated for the most part whenever changes have

been received. Dollar comparison information between various reimbursement formulas and Medicare is notably lacking because of the difficulty in interpreting the wide variety of third party formulas developed on the basis of local negotiation, the general absence of record keeping for specific dollars received from numerous insurance companies by each hospital, and the sparsity of fiscal-year financial closing and retroactive adjustments to providers for Medicare services.

The attached summary of reimbursement formulas of Blue Cross is based upon the review of 76 plan contracts which are the result of local independent negotiation between hospitals and each plan. Some 50 Blue Cross plans reimburse on a cost oriented basis and the remainder reimburse on a charge oriented basis. An analysis of this summary shows that more than two-thirds of the plans to reimburse hospitals on a basis which allows hospitals to recover more than the expenses of operation (including depreciation primarily on an historical cost basis). These reflect different ways of meeting the American Hospital Association's *Principles of Reimbursement* through local determination.

Comparison of the net effect of reimbursement of hospitals by the plans is difficult because of the numerous variations in control by the formula, treatment of direct payment by patients, accomplishment of computations, and inclusion of allowable costs in reimbursement. Further complications are added by the wide variety of benefit patterns that exist between plans and even within plans. For example, subscriber benefits are provided for group coverage, comprehensive plans, and non-group; each of these may contain various inclusions and exclusions. Direct payment is necessary by subscribers for some hospital services depending on type of contract and accommodation used. This summary explains in a general way the methods of reimbursement employed but does not completely explain the dollar amount of reimbursement to hospitals in light of the many permutations and combinations of other factors mentioned above. Furthermore, the data is always in a fluid situation inasmuch as plans are constantly reviewing arrangements with hospitals.

The Medicare program offered a single national benefit program for the first time. It was to this pattern we addressed ourselves in our consultations with Congress and the Administration. We felt that the AHA *Principles of Reimbursement* were particularly applicable to this program because the principles had been developed to express the economic needs which must be met through reimbursement to provide continuing effective hospital services for beneficiaries. This, we felt was the intent of Congress and our March 8 testimony reiterated the principles applicable to an effective national program.

Medicare reimbursement unlike many existing benefit and reimbursement programs combines a national standard of benefits with recognition of costs and operation. It has been the intent of AHA to make reimbursement under Medicare cover to the extent possible a fair share of total operating expenses. We do not believe that this intent has been met as yet because of deductibles and co-pay necessitated by budget allowances. Nor do we believe that economic needs of institutions have been fully met.

Virtually all of the commercial medical insurance coverage for patients is on an indemnity basis. As a consequence, hospitals are reimbursed by the patients, and the insurance companies (when the bill is assigned to the hospital) on the basis of established charges. In essence the commercially insured patient is the same as a self pay patient who pays a charge that reflects the full financial needs of the hospital as described in the American Hospital Association document, *Factors to Evaluate in the Establishment of Hospital Charges*. This document together with a copy of our *Statement on Reimbursement* is attached. Collections at charge rates must be made from these patients for deductibles, coinsurance, and non-covered benefits and for insurance covered benefits when not assigned. The same financial needs contained in the AHA's *Principles of Reimbursement* are applicable to the charges.

Some studies are being conducted in South Carolina, Virginia, and Connecticut on collection of income. All data is not yet analyzed, but preliminary indications are that Blue Cross provides the highest level of payment to hospitals whether compared to charges or cost related reimbursement.

Because of the short passage of time since the inauguration of Medicare and the inability of the hospitals in this period to have completed the closing of their accounts, we have been unable to review in any great detail the hospitals experience with Medicare. This has resulted to a great degree from the delay by the Social Security Administration in providing paid claims tapes required to be

used by hospitals in their annual reimbursement calculations. Because of this delay hospitals were unable to file their annual statements for retroactive adjustments with the intermediaries until some time in March. The lack of the data tapes has slowed down the potential for analysis of Medicare reimbursement, however some estimates were made of economic effects in California on the basis of the first few months experience. Also, we are receiving preliminary information from other sources who have had an opportunity to consider their early results that the current reimbursement provisions do not adequately cover the hospitals cost.

You may be sure of our real desire to review the completed results of the hospitals experiences with Medicare. To ascertain the details of the economic impact of the Medicare program we have asked the hospitals to provide us with copies of the annual statements for retroactive adjustments filed with the intermediaries by April 10 and those which will be filed up to April 30. While we evidently will be unable to furnish any composite report on a national basis in the near future, we would hope to be able to report to you promptly the results found in individual instances. You also asked during the course of the hearings that we furnish you current information on the over-all income and expenses of the hospitals. This information has now been reported by the hospitals and is currently being processed for the forthcoming *Guide Issue of The Journal of The American Hospital Association*. It is our hope that this information will be collated and in meaningful form sometime early in May. We will provide you a copy as promptly as possible.

May I again express our real appreciation for your courtesy at the hearings, and our desire to be of any possible assistance to the Committee in connection with its deliberations of H.R. 5710.

Sincerely yours,

KENNETH WILLIAMSON, *Director*.

ITEM A—SUMMARY OF DATA ON RECOGNITION OF HOSPITAL FINANCIAL NEEDS IN BLUE CROSS PAYMENT FORMULAS

Data collected in 1964 by BCA, updated subsequently whenever changes become known:

75 U.S. Blue Cross Plans:

52 cost oriented.

23 charges oriented.

Of the 52 cost oriented Plans—

35 recognize depreciation as cost on historic basis.

3 recognize depreciation as cost on replacement basis.

8 recognize a factor in lieu of depreciation as a cost.

6 may recognize, but do not specifically mention, depreciation as a cost.

Of the 35 Plans which recognize depreciation on historic basis—

5 have limits on allowable depreciation.

20 pay an additional "unearmarked" factor over defined cost, all but 3 pay this factor on a percentage of cost up to 10 per cent.

13 do not pay an additional "unearmarked" factor, but of these some recognize bad debts.

All 35 have a ceiling based on charges of which eight are less than 100% of charges.

Of the 3 Plans which recognize depreciation on replacement basis, one pays an additional "unearmarked" factor of 6%.

Of the 8 plans that recognize a factor in lieu of depreciation as a cost,

4 pay additional "unearmarked" factor over defined cost of up to 8%.

4 do not pay an additional "unearmarked" factor, but of these 2 recognize bad debts as a cost.

All 8 have a ceiling based on charges of which one is less than 100% of charges.

Of the 5 Plans that do not recognize depreciation as a cost—

All pay an additional "unearmarked" factor over cost from 7 to 11%.

All have a ceiling based on charges of which one is less than 100% of charges.

Of the 26 charges oriented Plans—

9 have a ceiling less than 100% of charges ranging down to 94%.

21 require advance notice of increases in charges.

13 require cost information to be submitted to justify charges.

STATEMENT ON REIMBURSEMENT

(Approved by Board of Trustees, Aug. 28, 1965)

PREAMBLE

The hospital system in the United States has been created by multiple interests and agencies but carries a strong precedent of creativity through voluntary action. It must be remembered that the hospital system in the United States is characterized by a diversity of ownership, government (local, state, and federal), nonprofit voluntary (community or religious sponsored), and proprietary. Financing for hospital service is provided through direct payment by the patient, taxation, nonprofit hospital service plans, and insurance. To some extent the acceptance of varying financial arrangements depends on the ownership and sponsorship of hospitals.

The object of every hospital is to provide services of the quality and quantity needed by the public it serves. It is essential that hospitals receive sufficient revenues to meet their current as well as future needs in order that they may fulfill this objective. The stewardship responsibility for the operation, preservation and development of hospitals is vested in a governing body charged with the establishment of policy and control in keeping with the hospital's fundamental purpose of achieving and maintaining optimum health care. In the total sense of exercising stewardship responsibilities and in the effective organization, management, and control of hospitals, the governing body, administration and medical staff share interrelated responsibilities.

The community in turn must recognize that the provision of optimum health care is influenced by various conditions such as physical structure, availability of skilled personnel, availability of adequate financing and many others. These factors vary with size, location and primary purposes of a hospital. Other elements in the cost pattern of a hospital are the extent of research and educational programs being carried out in its joint pursuit of the goal of optimum care and community service.

Ultimate responsibility for control of operating cost is best exercised by the governing body through policy and guidelines developed to meet the financial need. The prerogative of determining whether expenses may or may not be incurred cannot be exercised by other than the responsible governing body, because this could adversely affect the goal of optimum care.

In order to serve the public and to maintain and preserve the voluntary system, hospitals should receive remuneration for their services under a reimbursement program designed to meet the total fiscal needs of an ongoing organization. It must be recognized that the community responsibilities of hospitals create income needs that go beyond the simple recovery of out-of-pocket expenditures. Some of the specific items that create requirements for additional income include the acquisition and replacement of physical plant and equipment, the need for adequate working capital, the conduct of educational and research programs, and the provision of funds to provide services for indigent patients.

A hospital must demonstrate financial needs based on efficient and economical operation that embodies the highest standard of care possible within the facility's working environment. Uniform principles of accounting and uniform gathering of statistics should be followed to justify need. In addition, hospitals should involve themselves in areawide planning to prevent duplication of facilities when such duplication will lower quality of care and increase operating cost to the community. Further, there should be greater integration among the facilities designed to serve the various aspects of total community health needs, such as extended care and psychiatric units. Finally, it should be the joint responsibility of hospitals and the medical profession to administer the utilization of beds and ancillary services so that their efficient use is assured in treating the sick and injured and restoring them to the highest possible level of health.

In summary, hospitals are institutions of public trust. In the administration of the trust, the governing body must attend to the quality and quantity of care as well as assure the public of economical and efficient operation. It can only uphold these responsibilities through sound fiscal operation. In turn, the governing body has the right to expect that all purchasers of hospital services will accept the responsibility of adequately meeting current and future financial needs.

ENDORSEMENT OF PRINCIPLES OF PAYMENT FOR HOSPITAL CARE

The first edition of the *Principles of Payment for Hospital Care* was approved by the House of Delegates of the American Hospital Association in 1953.* In 1961 a special study led to a reappraisal and clarification of their basic substance. They were slightly modified again in 1963.

From this brief background, several observations can be drawn.

1. The principles have withstood the buffeting of an extended period of constant change brought about by the development and growth of hospitals and their subsequent accelerated financial needs.

2. The principles themselves have not been allowed to remain static, but have, in light of changing attitudes and conditions, been subject to repeated reevaluation.

3. Such reevaluation has resulted only in minor modifications.

Therefore, the American Hospital Association looks to the *Principles of Payment for Hospital Care* as its basic document in establishing its position regarding reimbursement to hospitals for services that they provide.

The *Principles of Payment for Hospital Care* set forth standards of adequacy and equity for reimbursement to hospitals.

INTRODUCTORY COMMENT

"The growth of programs by which third-party agencies pay hospital bills for groups of beneficiaries has raised important questions as to the amounts which should be paid to hospitals for care. Individual patients require different services and individual hospitals establish different regular charges for nominally similar services.

The differences in patient needs and hospital charges require special agreements between hospitals and third-party agencies whenever the former agree to furnish specific services, and the latter agree to make payments for those services. The payments must be adequate in total and equitable among hospitals.

"The third-party's liability to a hospital may be merely the payment of a certain dollar amount (indemnity or cash benefit) toward the charges for services rendered. Such liability does not require a contractual arrangement between the hospitals and the third-party agencies, except for such matters as extension of credit to patients or authority to make payments directly to the hospitals.

"Any contract to provide services should protect a hospital's financial interest and its program of public service. Payments should encourage high standards, administrative efficiency, institutional freedom, and the rendering of service in the interest of patient welfare.

"Two broad bases are available for developing a method of reimbursement of hospitals for service benefits, namely, the 'charges' established by the hospitals and the 'costs' incurred by them. The American Hospital Association publications, *Uniform Chart of Accounts and Definitions for Hospitals*¹ and *Cost Finding for Hospitals*,² are suggested guides for the determination of costs.

"The prevailing sociologic and economic factors and medicohospital relationships in a given area determine the degree of success or failure of any method of payment for hospital care. Because of the general public interest in hospital operations, any method of payment which enables a single agency to control the number of services rendered to patients and the charges established for such services is undesirable. Such control leads to interference in hospital management and can affect adversely the quality of care rendered to patients. Therefore, a system of payment which permits purchasers of large quantities of hospital care to gain control of hospital management is to be avoided.

"Payment of existing charges, as established from time to time by each institution, requires no special contractual arrangement.

"The conferences sponsored by the American Hospital Association and attended by representatives of both hospitals and third-party agencies, made only passing reference to established charges as the basis of contract payment for services in hospitals. The conference reports expressed the view that reimbursement

*Adopted by the House of Delegates, September 1953. Revised January 1962, September 1962, and August 1963.

¹ *Uniform Chart of Accounts and Definitions for Hospitals*. The Association. 1959. 173 p. \$2.25.

² *Cost Finding for Hospitals*. The Association. 1957. 131 pp. \$3.

from third parties should not exceed the total amounts charged to noncontract patients receiving similar care in the same hospitals.

"Under the principle of free enterprise, individual full-pay patients would expect to pay approximately the same amounts for the same services in the same community. But in the long run, established charges to individual patients cannot be expected to control the amounts paid by large-scale contractors who guarantee definite payments for all their clients. The amount paid by such a contracting agency will tend to equal the cost of the services rendered to its clients.

"A hospital or group of hospitals must, over a period of time, be reimbursed for the cost of services which they provide. Conversely, all responsible third-party contractors should be prepared to pay for the costs of services furnished to their beneficiaries. Many problems must be solved in the application of this fundamental principle.

"Individual hospitals face different financial problems. But they must deal with contracting agencies as a group. A contractual arrangement within a community must be guided by equity for the majority of hospitals which agree to provide service.

"The following principles of payment are intended to outline standards of adequacy and equity for contract payments for services furnished by hospitals to beneficiaries of third-party agencies, such as Blue Cross Plans, governmental bodies and other organizations which engage in the purchase of hospital services on behalf of groups of individuals."

1.000 BASIS FOR PAYMENT

1.000 "The amount and method of payment to hospitals should be such as (1) to pay fairly and adequately for services purchased, (2) to maintain essential services, and (3) to encourage the development of higher standards of service to meet the needs of the community.

"COMMENT. The financing of hospital care requires recognition of local differences in the financial needs of hospitals. The economic factors which influence financial solvency vary from community to community. The methods and amounts of reimbursement should recognize the financial needs of the hospital, should permit protection of capital assets, and should allow for the orderly implementation and expansion of necessary health services. The implementation and expansion of necessary health services should be guided through area-wide planning and should be such as to protect the public from construction of facilities unrelated to real need, and should limit unnecessary duplication. The hospital administrator, the governing board, and the medical staff must have assurance that the amount and method of payment will be adequate to cover the current costs of providing the services which are requisite to necessary care, and that payments can be adjusted from time to time to meet the cost of expanded and improved quality of care."

INTERPRETATION. The American Hospital Association directs attention to the comment under Principle 2.304, which recognizes that deficits resulting from bad debts and the net loss sustained in the care of indigent and medically indigent must be recovered if essential services are to be retained. The comment under Principle 2.304 establishes the appropriateness of including these items as factors of reimbursement under Principle 1.100. The American Hospital Association also recognizes that in equitable financing there is need for working capital and funds to develop higher standards of service to meet the needs of the community.

1.2000 "Agencies purchasing hospital services should pay the cost incurred in providing services for which they are responsible under their agreements with hospitals. Total payments to a hospital for such services for an accounting period should not exceed total hospital charges for these services.

"COMMENT. Hospital income from patients whose bills are the responsibility of a third party should equal the cost incurred by the hospital in providing a high quality of care. The term cost as used here assumes the acceptance of definitions of cost in the succeeding sections of this report. This principle also implies that both parties (agency and hospital) are agreed as to contract services that are to be provided and as to the method of computing the contract payments that are to be made."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

1.201 "A hospital should apply uniform principles for determining rates of reimbursement for similar services for third-party agencies.

"COMMENT. The formulas used for establishing contract payments by third-party agencies should be applied uniformly for all such organizations. The amount of contract payment necessarily will vary for different third-party agencies, if the agencies contract to pay for different types of services for their beneficiaries. The most important principle is that each third-party agency should contract to pay the cost of whatever services are agreed upon."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

1.202 "Third-party agencies should not be expected to pay for that portion of the cost of specific cases which has been or will be paid for from other revenues designated for such cases.

"COMMENT. A hospital should not receive income for the same service from two separate sources. A hospital, however, should not be expected to furnish services below cost to third-party agencies merely because it receives income for general purposes from some other source."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

1.203 "Established charges to self-paying patients for similar services and accommodations should be based upon and be reasonably related to the cost.

"COMMENT. Where established charges for self-paying patients are less than cost, it is difficult to justify contract payments from third-party agencies that are based on cost. Charity and other allowances should be granted on an individual basis and should not be a factor in setting charges. It is not practicable for the charge for every item of service to reflect its individual cost, but the composite regular charges for contract service should at least equal the composite costs of such care. (Further details refer to the Guiding Policy for Hospitals in Pricing Their Services to the Public.³)"

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

1.300 "Hospitals which are paid the cost of services they render to beneficiaries of third-party purchasers must accept the obligation of making available essential facilities and a high quality of service, with due regard to economy and efficiency.

"COMMENT. Hospitals which are paid cost must assume basic obligations to provide essential facilities and high quality service at minimal expense and maximal operational efficiency. The acceptance of this principle involves both self-imposed and externally applied judgments of adequacy, deficiency or extravagance of hospital administration."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

1.400 "Rates of payment should reflect current hospital costs.

"COMMENT. Rates of payment should be related directly to cost in the period in which care is given, insofar as administratively possible. A procedure for retroactive adjustment to current costs, or for determining an acceptable estimate of current costs, should be mutually agreed upon. This principle is important in that hospital costs must be met in terms of current price and wage levels. It is, therefore, in the interest of the third-party agency and the hospital to devise a method by which costs may be computed and payments adjusted promptly to reflect current variations."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

1.500 "Payments to different hospitals for the same service may differ.

"COMMENT. Hospitals differ in physical design, equipment, accessibility, location, legal responsibilities, community responsibilities, medical staff, percentage of utilization, and in many other details. For these reasons hospitals may provide comparable quality in specific patient services at varying unit costs.

"One hospital frequently is unable to maintain as high a percentage of occupancy or as complete utilization of diagnostic facilities as another institu-

³ Guiding Policy for Hospitals in Pricing Their Services to the Public. HOSPITALS, J.A.H.A., 34: 55 Aug. 16, 1960.

tion. This adversely affects costs. But even the resultant higher costs may be justified because of the need for stand-by service in the community."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

2.000 DETERMINATION OF REIMBURSABLE COST

2.100 "The determination of reimbursable cost requires acceptance and use of uniform definitions, accounting, statistics, and reporting."

"COMMENT. Any systematic payment program requires an orderly procedure of reporting in order that the payment program may be administered fairly and expeditiously. Hospitals must agree to provide the basic information necessary for comparable analysis of cost and equitable distribution of payments for third-party purchasers. Reimbursement at cost by third-party agencies is dependent upon their knowledge of the procedures used in providing the data. Only through uniformity of records and reports can third-party agencies be assured that they are paying for similar services in different hospitals on comparable bases."

INTERPRETATION. (1) The American Hospital Association recognizes that reimbursement may be determined without the use of cost analysis or cost finding. (2) Uniform records and reports do not necessarily require identical methods of accounting.

2.200 "The American Hospital Association publications, *Uniform Chart of Accounts and Definitions for Hospitals* and *Cost Finding for Hospitals*, should be used as guides in compiling financial and statistical data and in allocating and segregating costs.

"COMMENT. Official standard definitions, accounting procedures, statistical procedures, and methods of reporting among hospitals are those described in the American Hospital Association publications, *Uniform Chart of Accounts and Definitions for Hospitals* and *Cost Finding for Hospitals*. Their uniform use, nationally, will contribute to better accounting by the hospitals and better understanding of costs and cost factors by third-party purchasers."

INTERPRETATION. The publications *Uniform Chart of Accounts and Definitions for Hospitals* and *Cost Finding for Hospitals* are presently being revised. Certain groups of hospitals have used the publications at the local level as a base and by revision and amplification have developed them into effective accounting tools. The American Hospital Association is of the opinion that these manuals should be used as guides in the development of a reimbursement program.

2.300 "It is essential that the principle of reimbursement of hospitals at cost be embodied in a reimbursable cost formula. This may be used to determine the total cost of operations for the purpose of computing a general average cost per inpatient day or other unit of service. Such an average cost figure should be used when applicable to the services which a hospital or hospitals agree to furnish. Under other circumstances the average may serve as a basis for adjustment, up or down, according to the scope and content of an agreement with respect to cases covered, accommodations used, extent of services, or other major considerations.

"Attention is called to the recommendations indicated in 2.301 to 2.311 with respect to certain items which are sufficiently important to justify special mention for inclusion or exclusion in the computation of reimbursable cost.

"COMMENT. An average per diem cost, computed under a reimbursable cost formula, should be used to establish a rate of payment under contractual agreements with third-party agencies when the patients for whom a contracting agency is responsible are average for the hospital concerned.

"Patients paid for by specific third-party agencies may be atypical for a variety of reasons. For example, all patients might be hospitalized for obstetrical care, and reimbursable cost for this group might not be average cost for all patients in the hospital. A third-party agency might wish to have all of its beneficiaries hospitalized in semiprivate rooms which might cost more than average cost, or all beneficiaries of another agency might be chronic patients requiring long periods of hospitalization with relatively small amounts of special services at less than average cost. In such situations, it may be necessary to develop more detailed cost data or other factual information for the purpose of demonstrating the extent to which a reimbursement rate should deviate from the overall average patient day cost."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

2.301. "Identifiable expenditures made for medical research purposes, over and beyond the usual care of patients, should not be included in determining reimbursable cost of patient care and services.

"COMMENT. Research ultimately results in better patient care; its benefits usually are derived over long periods of time and are not always of direct benefit to patients in the hospital at the time the research is being conducted. It is, therefore, reasonable that such desirable pioneering efforts be financed from sources other than the patients being served in a particular hospital. Such other sources might be eleemosynary foundations, philanthropic contributors, and tax-supported agencies.

"Those paying for hospital care should understand that the quality of care in any hospital is improved by research and that any increased cost is reflected in better care because of the incentive provided for better service by those working in such a hospital."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

2.302 "In determining reimbursable cost, a reasonable amount for medical nursing and other education not reimbursed through tuition, or through scholarships, grants, and other community sources is a legitimate inclusion in the interest of continuing to upgrade quality of service to the community.

"COMMENT. Ideally, the cost of educating and training the technical and professional health services personnel needed for community service, for industry, or for other health activities should be financed by the whole community through a combination of public resources and private contributions, rather than by the sick patient representing a small percentage of the community who is usually in the poorest position to meet such cost. It will be necessary, however, that the cost of such programs be considered as a factor in determining reimbursable cost of hospital service until the community is prepared to assume this educational responsibility. Hospitals and third-party purchasers must seek methods for transferring this cost to the whole community through concerted joint effort. It must be borne in mind that nursing education traditionally has been supported by hospital income and by the service rendered by student nurses in hospitals. While financing from other methods must be developed, nothing must be done to discourage the education of increasing numbers of nurses prior to the time that such cost can be transferred to other sources."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

2.303. "Income specifically designated for research or education should be deducted from total hospital expenses to the extent that expenditures for such items have been included in the total cost.

"COMMENT. It appears justifiable to include the expense of some types of applied research and basic training programs as part of the cost of hospital operation. But in the event special contributions, government subsidies, or foundation grants are made available for financing these activities, in part or in full, such amounts should be recognized in the special purpose budget to which they apply as a reduction in the gross amount of the cost of such research or educational projects. To charge the patient for an expense that was met specifically in another manner would mean that income would be derived from two sources for the same expense."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

2.304. "Bad debts, the unpaid costs of care of the indigent and medically indigent, and courtesy allowances are deductions from earned income and should not be included in reimbursable cost.

"COMMENT. Adequate reimbursement from third-party agencies reduces hospital deficits incurred by reason of bad debts.

"All agencies which assume responsibility for the payment for hospital care of needy patients should be prepared to pay hospitals adequately as defined in Principle 1.200.

"Hospitals and third-party agencies should cooperate in seeking full community support for the hospital care of the indigent and medically indigent.

"It is apparent, however, that net operating deficits resulting from the foregoing factors must somehow be covered if essential services are to be main-

tained; Therefore, it may be appropriate that a reimbursement formula developed under the terms and provisions of Principle 1.100 give recognition to this fact.

"Courtesy allowances should not be recovered through patient income."

INTERPRETATION. Principle 2,034 is concerned with accounting methodology rather than with reimbursement on a cost basis. The American Hospital Association takes the position that deficits resulting from bad debts and the net losses on care of the indigent and the medically indigent are recoverable items, and provisions should be made in Principle 1,100 for their recognition in a reimbursable cost formula as a "cost of doing business." Employee fringe benefits, including hospitalization and personnel health programs should be recognized as operating expenses of the hospital and not considered courtesy allowances for employees.

2.305 "Ordinary remodeling is a charge against maintenance and repairs and should be included in expenses. Remodeling which enhances the capital value should be capitalized and, therefore, not included in reimbursable costs.

"COMMENT. Hospitals are expected to make the necessary expenditures required to maintain the original purpose and efficiency of the plant facilities and to do minor remodeling periodically to improve efficiency and economy of hospital operations. Such costs are properly chargeable to current operating expense. It is expected that expenditures for extensive remodeling or replacement of buildings for the purpose of enhancing the value of the hospital should be capitalized. Funds for such capital expenditures should be accumulated by regular depreciation allowances included in costs over a period of years or by some other type of financing, such as public subscription and philanthropic contributions."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

2.306 "Net interest at a reasonable rate incurred on capital or other indebtedness should be included in determining reimbursable cost.

"COMMENT. A hospital is a public service agency and, as such, represents a public investment in necessary community health facilities. If the public has not provided a debt-free institution, either through extended purchase of care or through public fund-raising campaigns, it must assume responsibility for the payment of debt service charges added to its bill for hospital care. Net interest is computed by deducting from gross interest paid, the income derived from investing the borrowed funds on which interest is paid."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation. It does wish to note that hospitals that include net interest as a cost factor should be able to demonstrate that the unit or units of capital expense, financed by borrowed capital, meet acceptable criteria of logical planning and sound financing.

2.307 "The expense incurred by hospitals in providing services of sisters or other members of religious orders shall be accepted as an operating expense for the determination of reimbursable cost. The amounts included should not exceed those paid other employees for similar work and should be identifiable in the records of the institution as operating expenses.

"COMMENT. Inclusion of a comparable value for the services of members of religious orders is a recognition of their contribution to community health and welfare. Equity among hospitals requires that each institution maintain records of the amounts included in the operating expenses for such services, with a list of the individuals for whom the amounts have been calculated. The total amounts may be subdivided in the records according to whether they represent living expenses, special prerequisites or salary allowances."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

2.308 "Income received from governmental agencies, foundations or others to cover special projects or salaries paid to special employees, who ordinarily would not be employed by the hospital, should be deducted from expense in the determination of reimbursable cost.

"COMMENT. Under some circumstances a hospital receives income from outside agencies toward the conduct of special projects or for the employment of specially trained personnel required to administer the treatment of specific types

of illnesses. Agencies sponsoring such special projects or services should pay the cost of the services sponsored on their behalf, in order that no part of the cost of these extraordinary projects need be paid by other patients, including the beneficiaries of other third-party agencies."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

2.309 "Reimbursable cost should provide for a separate cost for the nursery care of the newborn.

"COMMENT. Present-day standards of specialized care for newborn infants frequently represent a substantial portion of hospital operating expenses. The cost of such care should be computed separately in order that agencies which purchase predominant amounts of maternity care may pay their proportionate share of such hospital operating costs. Such classification of expense would make possible more accurate comparison of adult patient day costs among hospitals, irrespective of the variance in the amount of care provided newborn patients. Such information should also prove useful in determining charges for self-paying patients."

INTERPRETATION. From practical experience prepayment agencies have found the most logical approach to the acknowledgment of newborn days in a reimbursement formula is to count these days, apply a predetermined ratio and add the remaining result to the adult patient day count.

2.310 "Depreciation on buildings and equipment, in accordance with recommendations of the American Hospital Association publication, *Uniform Chart of Accounts and Definitions for Hospitals*, should be included in reimbursable cost, identifiable on the books of the hospital and acceptable for certification, and reimbursement for depreciation should be used for capital purposes.

"COMMENT. The rates of depreciation for various capital assets listed in the American Hospital Association publication, *Uniform Chart of Accounts and Definitions for Hospitals*, have gained widespread acceptance in the hospital field. Funds so provided under this principle should be deposited in a restricted account. Expenditures from these funds for implementation, expansion, or replacement of necessary health facilities should be in harmony with recommendations of area-wide planning groups. It is recognized that the exigencies of financial operation of hospitals may require borrowing from the funded depreciation reserves for purposes other than capital expenditures. If these funds are used for noncapital purposes, they should be charged to the General Fund and identified as a liability on the General Fund balance sheet."

INTERPRETATION. The American Hospital Association recognizes that the capital requirement needs of hospitals necessitate a reimbursement allowance based on current replacement costs.

2.311 "Expenses for inpatient and outpatient services should be segregated according to one of the methods advocated by the American Hospital Association in the publication, *Cost Finding for Hospitals*, or by a comparable method.

"COMMENT. The payment of cost for hospital care should be related to the services rendered. When paying for inpatient care, therefore, the rates of payment should not include costs of outpatient services."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

2.312 "Careful studies should be made of methods for adjusting general average costs to determine rates of payment applicable to particular agreements, having regard for their scope and content with respect to cases covered, accommodations used, extent of service, or other major considerations.

"COMMENT. There are some factors in the administration of patient care which can be identified and evaluated clearly. Examples are differences in accommodations, such as single, double, or multiple bedrooms, differences in categories of patients, such as chronic, aged or maternity, and differences in length of stay. When these differences in cost can be identified and evaluated, they form a proper basis for adjustments in rates of contract payment."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

2.400 "Hospitals should not be required to use income from general endowment funds or unrestricted gifts to reduce third-party payments.

"COMMENT. Endowment funds and gifts to hospitals are their property, and it is the responsibility of the hospital governing board to see that such funds are

administered in accordance with the wishes of the benefactors or on a basis by which the hospital can best serve the community."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

2.401 "Income from endowment funds or gifts designated by donors for the care of specific groups of third-party beneficiaries should be used to reduce third-party payments for persons in such groups.

"COMMENT. This principle prevents dual payments to hospitals. However, it must be interpreted with care in order that the endowment fund gift be defined specifically for the group who are the responsibility of the third-party agency. Such reductions in reimbursement from community agencies charged with the financial responsibility for general medical care of its indigent beneficiaries should be applied only to the care of the specific groups of patients for whom the gifts or endowment funds are available. It is not intended in this principle that such reductions in payment be used to affect payments from prepayment plans in which the individual has provided protection for himself through a form of insurance. Also, it is not the intent of this principle that unrestricted gifts or general endowment funds be used to reduce payments from third-party purchasers."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

2.402 "Hospitals should not be required to use net income from nonpatient service to reduce third-party payments.

"COMMENT. The net income from nonpatient service activities will affect the general revenue of the hospital. This does not relieve third-party agencies of their responsibilities for payment on the basis of reimbursable cost for patient services rendered. This principle does not affect the sale of obsolescent supplies and equipment since this income is a recovery from materials already charged to cost and such income should be credited to expenses."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

3.000 OBLIGATIONS IN APPLYING PRINCIPLES OF REIMBURSABLE COST PAYMENT

3.100 "When hospitals are paid reimbursable cost, hospitals and third-party agencies have the following obligations and responsibilities:

3.101 "Hospitals should assume responsibility for the provision of adequate facilities, competent personnel and high standards of service. Third-party agencies should assume responsibility for making payments for comprehensive hospital services.

"COMMENT. Hospital responsibility extends beyond the provision of minimum standards of patient care. Hospitals must incorporate in their health care program all essential services which high quality scientific medicine requires. Adequacy of facilities, personnel and standards of service should be judged on the basis of long-term public need rather than on short-term financial considerations. Likewise, third-party purchasers have a responsibility for developing programs by which all such services can be made available to their beneficiaries. Under such programs, third-party agencies must expect to pay the cost of such comprehensive services in order that the hospitals can continue to provide the highest possible quality of service."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

3.102 "Hospitals and organized hospital groups, in cooperation with third-party agencies, have responsibility for making studies which will lead to constant improvement in administrative and professional practices in both hospitals and third-party agencies. Such studies should be conducted for their educational value rather than for the purpose of establishing arbitrary controls.

"COMMENT. This principle does not intend that hospitals and third-party agencies shall conduct independent studies of each other's management, but that the two shall make joint studies of subjects of mutual concern and benefit. As the principle states, such studies will have educational value for the entire community as well as for the agencies concerned."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

tion, and is a logical assignment to the administrative intermediary under Public Law 89-97.

3.103 "Hospitals and third-party agencies should cooperate in the study of such factors as admission, length of stay, extent and amount of services provided, and other factors that affect the cost of services to agencies purchasing care, with a view to economical and efficient use of funds.

"COMMENT. The consideration of any factors which would tend to reduce the cost of hospitalization without sacrificing quality of care should be of mutual interest to hospitals and third-party purchasers. Continuous study of statistics and data bearing on hospital cost and third-party purchasers' experience should be carried on to promote all possible operational savings and benefits which will inure to the patient, the hospital and the third-party agency."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation, and is a logical assignment to the administrative intermediary under Public Law 89-97.

3.200 "There is a mutual responsibility on the part of hospitals and third-party agencies for making available, upon request, such fiscal and administrative statistics and data as are necessary for a continuing agreement on amount of payment and services provided.

"COMMENT. A purchasing agency has responsibility to demonstrate on occasions that its stewardship of funds is defensible. Further, the purchasing agency must have access to data regarding the product for purposes of defending such stewardship. Inasmuch as the third-party agency must secure adequate funds for hospital reimbursement, current and accurate data are required for predicting the amount of funds necessary for the agency to meet its obligations. For these purposes of mutual need, it is necessary that both hospitals and third-party agencies make fiscal and administrative statistics and data available for mutual study and understanding."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation, and is a logical assignment to the administrative intermediary under Public Law 89-97.

3.201 "Hospitals receiving payment on the basis of reimbursable cost agreements should provide accurate cost data based on an audit of their financial and statistical records which are capable of verification by those third-party purchasers with whom they have such agreements.

"COMMENT. Third-party purchasers must obtain adequate cost information from hospitals to which they are paying reimbursable cost in order to justify the payments they make for hospital care provided their beneficiaries. Such cost information must be kept in a clear and concise form which can be readily analyzed. It is a desirable practice to have an audit of the accounts of an enterprise by qualified, disinterested auditors. Such practice will ensure the provision of accurate cost information and is evidence of good faith and sound management."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation, and is a logical assignment to the administrative intermediary under Public Law 89-97.

3.202 "Hospitals are urged to organize in sectional or regional groups so that they may participate in joint service for uniform accounting, reporting and community planning.

"COMMENT. Uniformity in accounting, reporting and planning can be achieved through joint efforts and formally established lines of communication among hospitals. The promotion and development of uniform accounting and statistics, as outlined in the American Hospital Association publications, *Uniform Chart of Accounts and Definitions for Hospitals*, and *Cost Finding for Hospitals*, as well as many other projects, have been conducted successfully by metropolitan hospital councils, and by state or regional hospital associations."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

3.300 "Assumption of initiative in cooperation with appropriate agencies to develop objective criteria for evaluation of scope and quality of services of hospitals and third-party agencies is the logical responsibility of the American Hospital Association.

"COMMENT. The mutual interest of hospitals and third-party purchasers in the production and distribution of high quality hospital care suggests the need for a continuing program of self-analysis to ensure progress toward common objectives. The American Hospital Association is the logical agency to assume this undertaking, since it follows the established policy of the Association, as evidenced by its sponsorship and participation in a program of hospital accreditation and standardization."

INTERPRETATION. The American Hospital Association is of the opinion that this principle is applicable to all third-party agencies without further interpretation.

3.400 "The method and amount of reimbursement to contracting hospitals by third-party agencies should be established by mutual agreement of the parties concerned and should be based on the *Principles of Payment for Hospital Care*.

"COMMENT. If a hospital's costs depart substantially from other hospitals of similar size, scope of services and utilization, maximum reimbursement may be established through agreement reached between third-party purchasers and hospitals."

INTERPRETATION. It should be recognized that variation in hospital cost may be attributed to a variety of circumstances and, therefore, decisions as to whether a cost is unreasonable or not become a matter of judgment. To assure a maximum degree of equity, hospitals subjected to such judgments should be provided an opportunity to have their situation reviewed and evaluated by some appropriate agency.

CONCLUSION

With respect to the determination of payment rates, under contractual arrangements, the goal of the American Hospital Association is the development of a reimbursement formula that recognizes fully the cost of services received by beneficiaries of various third-party purchasers of hospital care. Methods of arriving at such determinations should be made the subject of careful study and the findings incorporated in a special manual or in a revised edition of the American Hospital Association's manual, *Cost Finding for Hospitals*.

FACTORS TO EVALUATE IN THE ESTABLISHMENT OF HOSPITAL CHARGES¹ APPROVED BY THE AMERICAN HOSPITAL ASSOCIATION FEBRUARY 3-4, 1966

INTRODUCTION

This statement was developed to aid hospitals to establish charges that are related to operating costs and other financial needs. Hospitals are obligated to establish just charges that will provide funds sufficient to ensure adequate financing of those needs that are the financial responsibility of patients, as opposed to those needs that should be met from other sources of revenue.

This statement is intended to set forth broad principles and does not deal with the methodology of implementation. The procedures explaining how these broad principles can be applied in determining individual charges for services rendered will be found in the rate-setting section of the revision, now in process, of *Cost Finding for Hospitals*. The revision will be entitled *Cost Finding and Rate Setting for Hospitals*.

The operation, preservation, and development of the hospital is the responsibility of its governing body, which is charged with the establishment of policies and programs and with the direction of resources to attain desired objectives based on community needs. These needs must be met in an effective, efficient, and economical manner. Planning for the development of services and expansion of facilities must be based on the concepts of areawide planning, in order to achieve maximum utilization of community resources to meet established community needs without inappropriate duplication.

Ultimate responsibility for the control of both income and cost is properly exercised by the governing body through specific fiscal policies developed to meet financial requirements. Since the fulfillment of community needs is a continuing and changing obligation of the hospital, the hospital's policies must be directed toward ensuring its future as well as its present financial stability. Revenue from all sources should equal total financial needs.

¹ G-263 © Copyright 1966 by the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611. All rights reserved. Printed in the U.S.A.

This statement correlates community needs with hospital objectives; defines the sources of revenue of hospitals and their total financial needs; further defines the bases for establishing charges and the responsibilities for meeting financial needs; and comments on the hospital rate structure and the obligation of adequate public disclosure.

DEFINITION OF TERMS

It is important that the terms used in this statement shall have the same meaning for all who read it. The terminology follows the accounting principles generally accepted in the field. Some specific definitions are as follows:

Working Capital: Working capital is the excess of total current assets over total current liabilities, and refers to that capital which is available at the moment for current use in the operation of the organization. As used in this statement the term refers to the investment necessary for financing current operations. In the operation of hospitals, as in most enterprises, there is a time lag between the date of payment for labor, goods, and services received and the date when collection is made for services rendered; and also, because of the necessity to maintain an inventory in order to have goods on hand when needed, there is a time lag between the receipt of goods and their use. As price levels increase and the scope of hospital activity expands, an additional amount of investment is required to finance these time lags.

Current Expenses: Depreciation expenses are definitely a part of current operating expenses, and are usually included with them. In this statement, however, in order to segregate the components of financial needs, depreciation expenses are included as part of the financial need titled "Preservation, Improvement, and Expansion of Plant Capital," and current expenses are defined as "all current operating expenses excluding depreciation."

Cost, Expense, and Loss: The terms "cost," "expense," and "loss" are often confused. They are defined in the following extracts from Terminology Bulletin Number 4, issued by the American Institute of Certified Public Accountants:

Cost is the amount, measured in money, of cash expended or other property transferred, services performed, or a liability incurred, in consideration of goods or services received or to be received. Costs can be classified as unexpired or expired. Unexpired costs (assets) are those which are applicable to the production of future revenues. Expired costs are those which are not applicable to the production of future revenues, and for that reason are treated as deductions from current revenues.

Expenses in its broadest sense includes all expired costs which are deductible from revenues. The narrower use of the term expense refers to such items as operating, selling or administrative expenses, interest, and taxes.

Loss is (1) the excess of all expenses, in the broad sense of that word, over revenues for a period, or (2) the excess of all or the appropriate portion of the cost of assets over related proceeds, if any, when the items are sold, abandoned, or either wholly or partially destroyed by casualty or otherwise written off. When losses of type (2) above are deducted from revenues, they are expenses in the broad sense of that term.

While the terms *cost* and *expense* are often used interchangeably, in this statement *expense* is used to denote expired costs, including those costs of plant assets that are applicable to the production of current revenues. When referring to a specific financial need, the term includes both direct expense and an appropriate allocation of indirect expense.

HOSPITAL OBJECTIVES

It is the responsibility of the governing board to establish appropriate hospital objectives after it has ascertained community needs, and has taken into consideration the community's financial ability to support the objectives and meet the needs. Traditionally, the objectives of the hospital have encompassed one or more of the following functions: care of the patient, education, research, and community health.

It should be noted that the traditional primary function of care of the patient is being fulfilled today not only through inpatient services but also through a wide variety of outpatient, ambulatory, and home services.

SOURCES OF REVENUE

Various sources of revenue are available to the hospital. Determination of the use of these revenues is a prerogative of the governing board unless they are donor-restricted, as may be the case with donations and grants or endowment income. Legally, revenues that are donor-restricted must be used in conformance with the donor's intent; that is, funds restricted by the donor to meet specified financial needs must be the first funds to be applied in meeting those needs. Revenues may be classified in six groups, according to source, as follows:

1. *Revenues from services rendered to patients.*—These revenues are earned for services to patients, wherever rendered, and are derived from paying patients or their third-party sponsors.

2. *Revenues from activities incidental to patient services.*—These revenues consist of items derived from those activities that are only incidental to patient care, such as commissions from rentals and from vending machines, and net earnings from snack bars, gift shops, parking lots, cafeteria, medical record transcripts, etc. The essential characteristic of these revenues is that they are the result of a voluntary action by the user of the service involved, who may or may not be a patient.

3. *Voluntary donations and grants.*—This revenue is derived from voluntary sources, such as contributions, requests, and foundation grants.

4. *Income from investments.*—This net income consists of the dividends, interest, rent, etc., earned on investments of other than the endowment fund.

5. *Income from endowments.*—This net income consists of the dividends, interest, rent, etc. earned on investments of the endowment fund.

6. *Government grants and tax levies.*—This revenue is derived from governmental sources such as tax levies grants and appropriations.

FINANCIAL NEEDS

The objectives of the hospital determine its financial needs which require funds for current expenditures and the prudent accumulation of funds for future expenditures. In order to achieve its objectives the hospital must receive sufficient funds to cover the following items of financial need where they exist:

1. Current operating expenses applicable to patient care;
2. Current operating expenses applicable to other functions;
3. Preservation improvement and expansion of plant capital;
4. Expansion of working capital; and
5. Funds to provide for contingencies.

Each of these financial needs will be examined in more detail; the justification for including certain elements of need in establishing charges will be noted; and the factors to evaluate in the establishment of hospital charges will be stated.

Each of these financial needs will be examined in more detail; the justification for including certain elements of need in establishing charges will be noted; and the factors to evaluate in the establishment of hospital charges will be stated.

*Item 1. Current Operating Expenses Applicable to Patient Care**Expenses for care of paying patients*

These are the expenses incurred for the care of paying patients who derive benefit from them either directly or indirectly. The care may be provided through various types of service as in inpatient or outpatient facilities or in the home, and the patient is responsible for the financial obligation incurred.

Items that go to make up these expenses include salaries and wages, supplies, purchased services, dues, interest, insurance, travel, taxes, utilities, fees and commissions, etc. Also classified as current operating expenses are expenses for those portions of educational and research programs that are applicable to patient service.

Factor 1.1: Charges for services to patients should cover current operating expenses applicable to their care.

Expenses for care of nonpaying patients

These are the expenses incurred for the care of the nonpaying patients, who derive benefit from the meither directly or indirectly. Items that go to make up these expenses are the same as for paying patients.

Credit losses: These patients receive hospital care and are responsible for the financial obligations that they incur; however, they fail to meet this responsibility and thus the expenses of their care must be financed through other means. In order to continue required service, the expenses of the care furnished to such patients become a part of the overhead expenses applicable to paying patients. The hospital is obligated to expend all reasonable efforts to keep credit losses at a minimum.

Factor 1.2: Charges for services to patients should include an appropriate factor to cover current operating expenses applicable to the care of those patients who give rise to credit losses.

Employee benefit: These patients are hospital employees who receive hospital care with the understanding that all or a portion of what would otherwise be their financial responsibilities will be waived. Such forgiveness of indebtedness is a fringe benefit and, as such, a wage equivalent.

Factor 1.3: Charges for services to patients should include an appropriate factor to cover current operating expenses applicable to the care of employees who are relieved of their financial responsibilities for such care.

Patients unable to pay: Certain patients in need of hospital care are accepted for care without financial obligation because they are unable to pay for part or all of the services provided. They are accepted because their care is recognized as the hospital's contribution to an essential community need. The hospital is obligated to exert reasonable efforts to have the community at large bear the expense of caring for such patients.

Factor 1.4: Current operating expenses applicable to patients unable to accept their financial responsibility for care should be financed first from funds designated for this purpose. Charges for services to patients should include an appropriate factor to provide additional funds required to finance any balance of current operating expenses resulting from the care of such patients.

Item 2. Current Operating Expenses Applicable to Other Functions

Expenses of educational programs

The education of physicians, nurses, and paramedical personnel requires the clinical facilities and practical experience best found in the hospital. That portion of the expenses of educational programs that contributes directly to patient care is considered an operating expense, as are expenses for inservice education of personnel and on-the-job training programs.

Educational programs also contribute indirectly to patient care. The existence of an educational program creates an atmosphere of intellectual stimulation that permeates the entire hospital. Such an atmosphere is conducive to improved patient care; each patient, whether directly involved in the educational program or not, benefits from its stimulating effects.

However, since educational programs are of benefit not only to patients but to the entire community, the hospital is obligated to exert reasonable efforts to seek funds to meet this financial need from community resources.

Factor 2.1: Charges for services to patients should include an appropriate factor for the net expenses of educational programs.

Expenses of research programs

The term *research programs* as used here refers only to formal programs. That portion of the expenses of research programs that contributes directly to patient care is considered an operating expense, as are activities such as methods improvement and infection control.

Research programs have a stimulating effect on the hospital and thus are conducive to improved patient care. Often the hospital is able to obtain the services of highly qualified medical staff members and professional personnel only because of the existence of research opportunities. In such cases, the patients receive direct and immediate benefit from the research programs.

Factor 2.2: The hospital is obligated to meet the expenses of research programs primarily with funds obtained through donations and grants, revenue from activities incidental to patient services, and endowment funds. However, charges for services to patients may include a reasonable factor to cover the unreimbursed portion of the expenses of research programs.

Expenses of community health programs

The detection and prevention of disease and the promotion of beneficial health practices is a universal goal in our society. The conduct and the expansion of community health programs are broadly beneficial. Health education and immunization and testing programs are examples of such activities.

The hospital with its organizational and physical resources has historically been a center for such programs. Its responsibility in the areas of preventive medicine and health education is a continuing one. However, it may seek funds from community resources to aid in financing such activities when they are conducted on a community-wide basis.

Factor 2.3: The financing of community health programs should be the responsibility of the entire community. Charges for services to patients may include a reasonable factor to cover the unreimbursed portion of the expenses of such programs.

*Item 3. Preservation, Improvement, and Expansion of Plant Capital**Preservation*

The stewardship responsibility of the hospital's governing body requires it to protect and preserve all capital entrusted to its care. The physical deterioration and obsolescence of plant assets and the effects of monetary inflation must be offset by replacement with other assets or by the reduction of plant debt. Only by so doing can the hospital ensure that its physical productivity is maintained substantially intact. To set aside only an amount equal to a depreciation charge based on the original cost would lead to the erosion of the existing investment in plant assets. It is not enough simply to recover the numbers of dollars that are thus invested. The depreciation charges for a given time period should represent the estimated current cost of replacing the plant assets used up in producing the revenues of that period. The hospital's obligation is to preserve plant capital in terms of today's value of the original dollar investment, thus taking into account the deterioration of the dollar through inflation.

Factor 3.1: Charges for services to patients should include an appropriate factor to provide the funds required to preserve plant capital.

Improvement

Once the governing board accepts responsibility for the stewardship of a hospital it also accepts, implicitly, the obligation to maintain a facility that provides all those services that the community has a reasonable right to expect from an institution of its size and nature, in the light of current hospital and medical practice. Thus, because of scientific and technological advances, it may be necessary to effect an actual increase in plant capital so that expected levels of services may be provided. Funds must be accumulated to meet this need for improvement.

Factor 3.2: Charges for services to patients should include an appropriate factor to cover the funds necessary for plant expansion due to improvement of services required to keep pace with technological and scientific advances.

Expansion

Significant increases in hospital capacity and resultant increases in service facilities may be required to meet expanded community needs resulting from factors such as population changes or the retirement of previously existing facilities. The hospital is obligated to carry out such expansion in strict conformance with community needs, and primary responsibility for financing is attributable to the community at large.

Factor 3.3: Expansion of physical facilities should be financed by funds received through donations and grants, revenue from activities incidental to patient service, and endowment income. Charges for services to patients may include an appropriate factor to provide any balance of funds required for expansion.

Item 4. Expansion of Working Capital

Responsible financial management dictates that the hospital's financial obligations be met as they become due. Working capital must be sufficient to finance operations during the time lag between the date when payment is made for salaries, supplies, and services, and the date when payment is collected for services rendered.

Additions to normal working capital are required when day-to-day operating conditions change, when price levels increase, and when technological and scientific advances expand the scope of activity due to improvement of services.

The hospital's governing authority must base its determination of needs for adequate working capital on sound financial principles, and it is obligated to exert all reasonable efforts to limit current requirements to those that are essential.

Factor 4.1: Charges for services to patients should include an appropriate factor for financing additions to working capital other than those required for plant expansion resulting in increased capacity.

Expansion

Significant increases in hospital capacity and resultant increases in service facilities and volume of activities require additions to working capital. The primary responsibility for financing is attributable to the community at large.

Factor 4.2: Needs for expansion of working capital created by plant expansion resulting in increased capacity should be financed by funds received through donations and grants, revenue from activities incidental to patient service, and endowment income. Charges for services to patients may include an appropriate factor to provide any balance of funds required for expansion of working capital required by increased capacity.

Item 5. Funds to provide for contingencies

The hospital is obligated to ensure its uninterrupted operation even during times of temporary financial stress. Sound financial management requires the prudent and reasonable accumulation of funds to protect the hospital against unpredictable conditions that might adversely affect its economics, such as community disasters, temporary interruptions of operation, strikes, and uninsured losses.

Factor 5.1: Charges for services to patients should include an appropriate factor to provide the funds required to protect the hospital against the effects of unforeseen adverse economic conditions.

HOSPITAL RATE STRUCTURE

The hospital's overall revenue must be adequate to meet its financial needs. However, the rate charged for each individual service should reflect properly the operating expenses of the service rendered plus an equitable share of the other financial needs for which the patient is responsible. Rates established on this uniform basis should be applied to all patients without differentiation.

A general service charge should be established for all commonly used services and supplies provided in relatively equal quantities to all patients. Uniform rates should be established for special or ancillary services and supplies that are not provided in relatively equal amounts to all patients, provided such services and supplies have a sufficient monetary and control value to justify making a separate charge. To simplify the rate structure, however, the hospital may choose to combine units into a flat rate.

The equity of the rate structure should be evaluated on a regular basis and appropriate adjustment should be made as required. Rates should be revised whenever there is a significant change in the financial needs of the hospital. An explanation of individual rates should be provided for review by those who have a legitimate interest in this explanation.

PUBLIC INFORMATION

The hospital has an obligation to inform the community concerning its financial position and the results of operations. Such information should cover the transactions in all funds, and should include:

1. Balance sheet;
2. Statement of changes in capital accounts;
3. Statement of operations; and

4. Accompanying explanations as needed to enable the reader to evaluate those hospital programs and operations that cannot be understood from the financial data alone.

These financial statements should be prepared in accordance with generally accepted accounting principles consistently applied, and should be accompanied

by the stated opinion of an independent certified public accountant as to their adequacy.

The hospital has a responsibility to disclose to the public evidence that all its funds are being effectively retained, expended, or utilized for the sole benefit of its patients. Such disclosure will be deemed to have been made if the data described are made available on request to patients and their third-party sponsors, to hospital benefactors, and to other persons who may have legitimate interest in this information. In addition, annual publication of all or part of such data in newspapers or other media may be desirable.

Mr. Boggs. Mr. Chairman, I would like to ask permission at this point in the record of the hearings to include a letter received by me from Mr. Herschel N. Knight, attorney for the Jennings American Legion Hospital at Jennings, La.

The CHAIRMAN. Without objection, the letter from Mr. Knight will appear at this point in the record.

LAW OFFICES OF KNIGHT & KNIGHT,
Jennings, La., March 8, 1967.

Congressman HALE BOGGS,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN BOGGS: I called your office and spoke to your administrative assistant concerning the current hearings on H.R. 5710, which apparently are certain amendments to the Medicare law.

For background, I represent the Board of Directors of the Jennings American Legion Hospital in Jennings, Louisiana. The hospital is located within the confines of the District of my good friend and ex-classmate Congressman Edwards, who will receive a copy of this letter. I have talked to his administrative assistant by phone and she will bring forth these views as set out herein to his attention, and he will likewise receive a copy of this letter and hopefully all of the congressional delegation from Louisiana will likewise be a recipient of this letter.

Our hospital is owned and operated as a non-profit corporation by the members of the American Legion of Jennings, Louisiana. We have a most modern plant, that is within ten years old, costing in excess of one million dollars. We did receive Hill Burton matching funds for construction of this facility.

We had certain misgivings in embarking upon this Medicare program because we felt that we could not make profit on the program but what was most serious was that we thought that we could suffer a severe loss. This hospital must support itself insofar as its operations, etc. are concerned, so at this juncture, it is much like a private business, except we do not pay income tax. However, no member can benefit from any profit that is made and this hospital stands as a monument to the Veterans who have come before us and do still exist, providing medical attention of the highest sort to the citizens of our area.

We are greatly disturbed with Section 12 of the House Bill 5710 entitled "Medicare Payments and Medical Facility Plan."

As we understand it, under the current law, the cost which the Government will reimburse to the hospital includes 100% depreciation on that portion of the hospital facilities that are related directly to the Medicare or aged program. In short, no depreciation is granted for the obstetrics ward for it is obvious that it would be unusual that patients of 65 years of age would be having babies and some other like facilities.

The disturbing thing about Section 12 is that we will be reimbursed for a reasonable cost which would include the 100% depreciation factor, less those portions of the physical facilities which are not related to the aged, but these funds would have to be kept by a State Agency or administered by them in some sort of way. This would mean, for example, if our depreciation were 2 or 3% or 10% of the one million dollars or more this money would be held by some State Agency and then we would have to petition this agency for the use of these funds. They would determine whether we would need repairs, they would determine whether we would need additional facilities, they would determine the use of these funds in their totality. Obviously, the State Agency would not be in a position to know the needs of the hospital involved without a number of investigators, high payroll and administrative costs, etc.

Can you imagine if the Congress of the United States would enact a law which would have to deposit with the State or Federal Government their reserve for depreciation, subject to administration by the Federal Government, what this would do to the profit and loss factor of that corporation, individual and/or business. This is what this amounts to. Be very sure that the Medicare program is based upon absolute cost to the hospital itself. Now, we should have the right to use the depreciation reserve funds to offset other losses, this must be within the discretion of each hospital, because each hospital has a different problem financially.

As you are no doubt painfully aware, when somebody else has to watch somebody else, it costs a lot of money.

I can certainly see that some hospitals will have to use funds from the depreciation account to maintain their operative costs. Many businesses do exactly this. But the Government under the Medicare program has imposed upon the privately owned hospitals of this nation the duty to take care of the senior citizens at cost. That means there is no profit in the program.

We will not participate in this program after the first year, unless we see that we are not losing too much money by so doing and this will involve a number of facts, like who was a paying patient as an elderly citizen before and who now comes in with a social security card and does business with us at cost. At the end of this year, we will be able to determine whether we can break even or not. At that juncture, we fully intend to make a decision whether we will continue with this program. I can certainly assure you and the Congress of the United States of America that if we do not receive 100% depreciation computed in the reasonable costs of Medicare paid directly to us, we will not participate in this program further, because we will no doubt be broke if we continued.

I have given some consideration to this matter and I have some convictions relative thereto.

I question first, Congressman, that we should enact elaborate laws setting up elaborate administrative procedures for the purpose of slowly liquidating the privately-owned hospitals in this country.

Why don't we simply get to the point and have the Government of the United States of America take over all hospitals, paying a reasonable market value to those who own them and then the Government can do with them what they want to. Then all these laws would not be necessary and the problem would all be in Washington and then we can abdicate another small portion of private enterprise to the Government of the United States of America. Most of the members of our Board have served approximately 15 years without pay in order to provide a modern hospital facility for our area. We were motivated solely by charity and being ex-veterans, we felt that this was a worthwhile enterprise for our endeavors.

I, for one, and I think this would be the unanimous view of our Post of the American Legion, that by slow attrition if we are going to be choked to death in the hospital business, then why put in another 10 or 15 years for free to see the inevitable happen?

I hope that this letter is submitted to the Mills, House Ways and Means Committee and receives at least a passing consideration by the Committee.

If you are down in our area, stop by and see us. We wish you well.

Sincerely yours,

HERSCHEL N. KNIGHT,
Attorney, Jennings American Legion Hospital, Inc.

The CHAIRMAN. Our next witness is Mr. Leon Goodman. Mr. Goodman, if you will identify yourself for our record by giving us your name, address, and capacity in which you appear, we will be glad to hear from you.

STATEMENT OF LEON GOODMAN, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS

Mr. GOODMAN. Thank you very much.

The CHAIRMAN. I might state to Mr. Fleming and to Mr. Erickson that we will continue without interruption through the remainder of the calendar. Go ahead, Mr. Goodman.

Mr. GOODMAN. My name is I. Leon Goodman. I am the executive director of the Federation of American Hospitals, the executive offices of which are located at 1450 Broadway, New York City.

The CHAIRMAN. We are glad to have you with us and you are recognized, sir.

Mr. GOODMAN. I appreciate the opportunity to appear before you today to express the federation's opposition to the required funding of depreciation allowances, as would be mandated by H.R. 5710.

The federation has served the proprietary hospitals of the Nation for nearly one year. Members now number 137 hospitals in 19 States.

These hospitals importantly contribute to the health of the American people. Last year federation hospitals treated approximately 300,000 patients. The 12,334 beds of the federation member hospitals have a capacity of 4,501,910 patient days.

Many of the Nation's proprietary hospitals have long histories, and great traditions of excellence. More typically, however, proprietry hospitals are young, founded by physicians or civic leaders to meet the health needs of the new communities that grew up during the postwar period.

In Nassau and Suffolk Counties in New York State, for instance, proprietary hospitals have been created to fill the vacuum in health care that arose with the huge population growth of these two suburban areas.

Today, nearly five out of 10 Nassau and Suffolk hospitals are proprietary institutions. In the New York City metropolitan area, as a whole, proprietary hospitals comprise one-quarter of all hospital facilities. Large concentrations of proprietary hospitals are also found in such fast-growing areas as California and Texas. Nationally, approximately one out of every 10 hospitals is a proprietary institution.

Proprietary hospitals are highly significant to the economies of their communities. Last year, federation hospitals employed 16,045 persons and maintained payrolls of \$55,794,425. Local taxes came to \$7,205,691. Moneys paid into the economies of the local communities served totaled \$123,463,142.

The proposed implementation of Public Law 89-97 last year made clear to the proprietary hospitals that the needs of the free enterprise sector of the hospital industry had not been effectively presented to Congress or the Administration. The payments formulae promulgated for titles 18 (medicare) and 19 (medicaid) would have actually prejudiced the continued existence of the proprietary hospitals.

The first, most urgent, order of business was for proprietary hospitals to make it understood that they could not long work with the proposed payments formulae, and stay out of bankruptcy. And it was for that reason that a few proprietary hospitals took the initiative of forming the Federation of American Hospitals, Inc.

Our problems are today better understood on Capitol Hill and within the Department of Health, Education, and Welfare. Although further improvements must be achieved, the first, grossly unfair payments formulae have now been modified.

But the fact that many public officials remain unaware of the different needs of the proprietary and voluntary hospitals still underlies federation's difficulties. It is in this regard that I shall today discuss

those provisions of H.R. 5710 that would require funding of depreciation.

The most important aspect is that there is a difference in capitalization between proprietary hospitals and voluntary institutions. Proprietary hospitals are developed by the investment of private capital. Substantial investment is required. The capital invested generates borrowing power for long-term debt, for either building or acquiring these institutions.

On the other hand, the capitalization of voluntary hospitals is characteristically all donated. The funds are received from philanthropic sources, community solicitation, and usually Hill-Burton grants. The tax deduction granted those donating to these institutions is sufficient grace for their benefaction.

It is, therefore, imperative that the distinction between proprietary and voluntary institutions be borne in mind before adoption of any rule on capital expenditure that affects both kinds of hospitals.

Proprietary hospitals must repay their obligations. They are in business. Voluntary hospitals are not subject to the rigors of the capital market. Their assets are entirely contributed.

The funds generated by the depreciation allowance are material and necessary to pay off long-term indebtedness: Depreciation allowances are tremendously important to the development of proprietary hospitals. By generally accepted practice these funds capitalize the construction and equipping of proprietary hospitals.

The long-term debt required for such development can only be amortized with the funds available through depreciation. It is this simple: Unless the funds generated by depreciation are forthcoming to reduce these debts, proprietary institutions will be forced out of business.

The payments of interest on debt and the funding of a depreciation reserve do not pay off the debt itself. If a hospital devoted all its beds to medicare patients, how could it ever amortize its debts under the proposed law? And, if some of its patients are nonmedicare, must their charges bear the full burden of amortization?

The only way proprietary hospitals can generate a cash flow to amortize long-term indebtedness is through depreciation:

Proprietary hospitals cannot go to their communities or private philanthropies to raise money. No tax benefits would accrue to those donating to our private hospitals.

But loss of depreciation funds for payment of long-term capital debts would gravely complicate the capital requirements of proprietary institutions. They would be required to return to their investors for additional capital to maintain payment on long-term debt, and there would be no assurance that these investors would be able to recapture their investment.

This is scarcely the climate to encourage a prudent investor. Nor would it help produce the additional health facilities so urgently necessary to fulfill the intended purpose of the medicare legislation.

In addition, the funding would also create another situation which requires some thought and that is that the cash position of proprietary institutions would be jeopardized by the required funding of depreciation.

Most proprietary hospitals presently have the bulk of their cash producing assets in accounts receivable. For the average member of the federation, accounts receivable have, in fact, substantially increased in recent years. Today average accounts remain open for 65 to 90 days.

As a result if we fund title 18 and title 19 programs, the Federal Government faces either of two additional burdens: Heavy accounts receivable margins will require these hospitals to borrow money and thus insure interest payments which are chargeable as a cost, or the Social Security Administration is put upon for interim financing, by the way of advances from the intermediary to the hospital against accounts receivable.

If it is required that depreciation be funded, the proprietary hospital would be further pinched for working capital.

This would require additional borrowing, thereby increasing the cost. No limitation in funding of depreciation would, on the other hand, reduce debt and working capital needs, and make it possible to avoid further debt burden.

Depreciation has universally been accepted by private capital as a means of payment for assets acquired as it was used: Depreciation is an actual cost of the operation of any hospital. This has been fully recognized by the Department of Health, Education, and Welfare.

If such cost is to be returned to the provider with the strings attached to it, as contemplated by the proposal before this committee's consideration, it will not encourage free capital to continue modernization of our hospitals. An array of new medical technology would fall out of reach. And, as you appreciate, our patients would suffer.

It is argued that use of depreciation must be restricted so as to prevent duplication and uneconomical utilization of resources. Certainly the proprietary hospitals, working in a free enterprise context, understand and support the concept of efficiency.

After all, the proprietary hospitals can point to a record showing they generally serve their communities and treat the ill for less cost than other hospitals. This, I believe, is one more testimonial to the values of competition and free enterprise.

There is ample machinery at the present time to guard against inefficiency and superfluous development of health care facilities. I refer to the regional planning councils, some 70 of which are presently operating throughout the United States and I have appended a list of them to my report.

These councils bring together medical and community leadership working to synthesize community medical needs and available resources. The system has just during the last year been buttressed in New York State by State law which provides that the councils will advise the State health department on the efficacy of plans to construct or enlarge all health facilities.

I know that this committee is concerned with the possible abuse of depreciation allowances. Those who are proposing the required funding of depreciation allowances have argued that the present system puts the Government in a position where they twice, or even three times, reimburse hospitals for capital expenditure. The first payment is in the initial Hill-Burton grants, the second is in the form of

depreciation allowances, and the third may arise when the hospital receives a further grant for construction or equipment.

The important point to keep in mind, however, is that the only hospitals that may so embarrass the Government are voluntary hospitals. It is only they that have in the first instance received Government grants.

Proprietary hospitals are ineligible for such grants and can only seek capital in the marketplace, or from among doctors and community leaders determined to provide hospital protection for their fast growing communities.

Thus, it is clear that proprietary hospitals are in no position to so abuse depreciation allowances. It is equally clear, I submit, as required by the dynamics of free enterprise that proprietary hospitals must be entirely free to utilize their available funds, including depreciation allowances.

The record amply indicates that when titles 18 and 19 were developed, both the House and Senate committees fully appreciated the importance of the depreciation allowances.

There was, to be sure, some question as to the administration's rationale for depreciation on publicly financed and otherwise donated assets, and that is the germ of what the proposed legislation now seeks to resolve. But, the record makes entirely evident that there was general understanding that depreciation is an accepted cost.

Additional clarification is necessary for definition of capital expenditure.

Only one additional point should be noted. The proposed legislation would require hospitals to receive permission to make any capital expenditures. Such a regulation can only generate problems.

For example, precisely what is a capital expenditure? Would it include modernization of existing facilities, major construction alterations, or new technological improvements? Might it even go so far as to include individual pieces of equipment, such as resuscitators, and other technology required in the day-to-day operation of a hospital?

And what sort of redtape would be involved in obtaining permission to buy a piece of lifesaving equipment urgently needed? How long would it take? What happens to the patient meanwhile? During the last few years the city of New York has piled an extra level of bureaucracy upon its municipal hospitals. The newspapers have been full of the scandalous accounts of what has happened as a consequence. Private enterprise cannot operate in such an atmosphere.

CONCLUSION

If it is the desire of Congress to encourage the investment of private capital to construct, maintain, and utilize facilities for participation in the health needs of the country, it is imperative that there be no restriction on the use of the funds generated through depreciation. Any restriction would preclude any possibility of return on invested capital.

In addition, it would prevent the payment of long-term obligations. Such default would mean the bankruptcy of the proprietary hospitals and put them out of business. If that should be the intention of the

Congress, then it should arrange for the purchase of the proprietary hospitals in accordance with the applicable provisions of law, not starve them or use attrition as a means of accomplishing this purpose.

The proprietary hospitals of the country have repeatedly been put to a disadvantage because their distinct responsibilities and needs are inadequately understood by the Nation's policymakers. This proved to be the case, as I mentioned, in the development of titles 18 and 19, and now underlies our manifest difficulties with the proposed funding of depreciation.

Gentlemen, proprietary hospitals offer outstanding hospital services to a significant proportion of the Nation's ill. Their dynamic is that of free enterprise, and if they are to expand, even survive, they cannot bear more restrictions than those who operate in other free enterprise sectors.

Where special restrictions are found to be necessary on the voluntary hospitals, it must be understood that those should not automatically pertain to proprietary hospitals. The two groups provide similar services but are of an essentially different organizational character.

It is most unfortunate that due recognition has not been afforded the difference between the free enterprise system of health facilities, and the facilities which are constructed through donated or Government funds. Our hospitals will remain in jeopardy until Congress recognizes the fundamental difference between eleemosynary institutions and those required by the laws of the capital market to show a continuing return on capital, as well as record of service to the community.

Thank you, gentlemen.

(The information referred to follows:)

ORGANIZATIONS ENGAGED IN AREAWIDE PLANNING FOR HOSPITALS AND RELATED HEALTH FACILITIES

ALABAMA

East Central Alabama Health Facilities Planning Association, Anniston, Alabama.
Birmingham Area Health Facilities Planning Association, Inc., Birmingham, Alabama.

ARIZONA

Health Facilities Planning Council Phoenix, Arizona.
Hospital Planning Council for Greater Tucson, Inc., Tucson, Arizona.

CALIFORNIA

North Coast Health Facilities Planning Association, Inc., Eureka, California.
Regional Health Planning of the South San Joaquin Valley, Visalia, California.
Hospital Planning Association of Southern California, Los Angeles, California.
Hospital Planning Council for Sacramento, Yolo and Placer Counties, Sacramento, California.
Hospital and Health Facility Planning Council of San Diego County, San Diego, California.
Bay Area Health Facilities Planning Association, San Francisco, California.
North San Joaquin Valley Regional Health Council, Stockton, California.

COLORADO

Colorado Hospital Service, Denver, Colorado.

CONNECTICUT

Health Care Facilities Planning Council for Greater Hartford, Inc., Hartford, Connecticut.

DISTRICT OF COLUMBIA

Health Facilities Planning Council for Metropolitan Washington, D.C., Washington, D.C.

FLORIDA

Health Facilities Planning Council of the Jacksonville, Area, Inc., Jacksonville, Florida.

GEORGIA

Community Council of the Atlanta Area, Inc., Atlanta, Georgia.
Health & Hospital Planning Council for Metropolitan Savannah, Inc., Savannah, Georgia.

HAWAII

Health Facilities Planning Council of Hawaii, Honolulu, Hawaii.

IDAHO

Hospital Planning Council of Southwestern Idaho and Eastern Oregon, Boise, Idaho.

ILLINOIS

Hospital Planning Council for Metropolitan Chicago, Chicago, Illinois.

INDIANA

Indianapolis Hospital Development Association, Inc., Indianapolis, Indiana.

IOWA

Health Facilities Planning Council of Greater Des Moines, Des Moines, Iowa.
Dubuque Area Health Facility Planning Board, Inc., Dubuque, Iowa.

KANSAS

Kansas Health Facilities Information Service, Inc., Topeka, Kansas.

MAINE

Health Facilities Planning Council, Augusta, Maine.

MICHIGAN

Greater Detroit Area Hospital Council, Inc., Detroit, Michigan.
Greater Flint Area Health Facilities Planning Council, Flint, Michigan.
United Community Services of Grand Rapids and Kent County, Inc., Grand Rapids, Michigan.

MINNESOTA

Arrowhead Region Planning Council for Health Facilities and Services, Duluth, Minnesota.
Joint Staff of the Metropolitan St. Paul and Minneapolis Hospital Planning Councils, St. Paul, Minnesota.
Central Minnesota Planning Council for Health Facilities and Services, St. Cloud, Minnesota.

MISSOURI

Hospital Planning Council for the Kansas City Metropolitan Area, Kansas City, Missouri.
Metropolitan St. Louis Hospital Planning Commission, Inc., St. Louis, Missouri.

NEBRASKA

Lincoln Hospital and Health Council, Lincoln, Nebraska.

NEW JERSEY

Hospital and Health Council of Newark and Vicinity, Newark, New Jersey.
Health Facilities Planning Council for New Jersey, Princeton, New Jersey.
Hospital Planning Association of Mercer County, Princeton, New Jersey.

NEW YORK

Regional Hospital Review and Planning Council of Northeastern New York, Inc., Albany, New York.
Hospital Review and Planning Council of Western N.Y., Inc., Buffalo, New York.
Long Island Hospital Review and Planning Council, Inc., Hicksville, New York.
Hospital Review and Planning Council of Southern N.Y., Inc., New York, New York.
Rochester Regional Hospital Council, Inc., Rochester, New York.
Health Council of Monroe County, Inc., Rochester, New York.
Hospital Review and Planning Council of Central N.Y., Inc., Syracuse, New York.
Community Health Information and Planning Service, Syracuse, New York.

NORTH CAROLINA

Health Planning Council for Central North Carolina, Durham, North Carolina.
Citizens Planning Council of Forsyth County, Inc., Winston-Salem, N. Carolina.

OHIO

Community Chest and Council of the Cincinnati Area, Inc., Cincinnati, Ohio.
Regional Hospital Planning Board, Cleveland, Ohio.
Columbus Hospital Federation, Columbus, Ohio.
Hospital Planning Council of the Greater Miami Valley, Dayton, Ohio.
Hospital Planning Association of Greater Toledo, Inc., Toledo, Ohio.

OKLAHOMA

Community Council of Oklahoma City and County, Oklahoma City, Oklahoma.

OREGON

Lane County Areawide Planning Council for Hospital and Medical Care Facilities, Eugene, Oregon.
Klamath County Area Planning Council for Medical and Health Facilities, Klamath Falls, Oregon.
Regional Health Facilities Planning Council, Medford, Oregon.
Hospital Planning Council for the Metropolitan Portland Area, Portland, Oregon.
Mid-Willamette Valley Council of Governments, Salem, Oregon.

PENNSYLVANIA

Lehigh Valley Hospital Planning Council of Eastern Pennsylvania, Bethlehem, Pennsylvania.
Hospital Survey Committee, Philadelphia, Pennsylvania.
Hospital Planning Association of Allegheny County, Pittsburgh, Pennsylvania.

RHODE ISLAND

Rhode Island Health Facilities Planning Council, Inc., Providence, Rhode Island.

TENNESSEE

Mid-South Medical Center Council for Comprehensive Health Planning, Inc., Memphis, Tennessee.
Nashville Metropolitan Region Health and Hospital Planning Council, Nashville, Tennessee.

TEXAS

Amarillo Area Foundation, Inc., Amarillo, Texas.
North Texas Planning Council for Hospitals and Related Health Facilities, Dallas, Texas.

WASHINGTON

Health Facilities Planning and Development Board, Inc., Seattle, Washington.
Inland Empire Health Facilities Planning Council, Inc., Deer Park, Washington.

WEST VIRGINIA

Hospital Planning Council of the Kanawha Valley, Charleston, West Virginia.

WISCONSIN

Hospital Area Planning Committee, Inc., Milwaukee, Wisconsin.

 ORGANIZATIONS ENGAGED IN DEVELOPING HEALTH FACILITY PLANNING PROGRAMS

CONNECTICUT

Connecticut Hospital Planning Commission, Inc., New Haven, Connecticut.

FLORIDA

Florida Hospital Research and Education Foundation, Orlando, Florida.

INDIANA

Indiana Health Facilities Planning Program, Indianapolis, Indiana.

MICHIGAN

Michigan Health Facilities Planning Council, Lansing, Michigan.

MINNESOTA

Joint Program for Development and Coordination of Local Health, Minneapolis, Minnesota.

OHIO

Ohio Hospital Association, Columbus, Ohio.

The CHAIRMAN. Thank you, Mr. Goodman. Are there any questions of Mr. Goodman?

Mr. UTT. I have one.

The CHAIRMAN. Yes, Mr. Utt.

Mr. UTT. Mr. Goodman, we recognize that depreciation is an essential cost of doing business in a hospital or anywhere else. Now, if you are not allowed depreciation, and proper depreciation, on medicare patients don't you have to make that up in what you charge the other sector of your patients?

Mr. GOODMAN. Yes, we do and this would be a cost that would be in addition to what their customary charge would be. Someone has to pay for it.

Mr. UTT. One of the things when we had a full discussion on social security was the assurance that there would be no shift from the medicare patient on to the under 65 patients to increase their burden, and apparently the lack of depreciation allowance is making that shift.

Mr. GOODMAN. No; we do get a depreciation allowance under the present reimbursement formula. However, under the proposed bill if you will require us to take that allowance and place it in the fund for utilization of new facilities, this means that we will not be able to utilize that cash generated to pay off the obligations that we have already assumed.

I will illustrate it very simply I think. Proprietary hospitals usually invest one-third of the total amount of capital required in cash. Let's assume that the hospital will cost \$3 million. They will put \$1 million up and borrow the other \$2 million on a long-term mortgage, over a 20- or 25-year period. They depend on the depreciation to generate sufficient cash to amortize that 20-year obligation, and this is true, incidentally, of many of the voluntary institutions, particularly in the California area, where they have bond issues they float for that purpose.

If you are going to isolate this amount of money and not allow them to use it, somebody else is going to have to pay for it to pay off these debts or they will go out of business.

I think that, as I understand the record, and I think the Senate Finance Committee had a very long discussion, Senator Anderson particularly thought that it was grossly unfair that the Government should pay for this grant first by depreciation and then giving it to them and let them use it for whatever they want and when the time came for the new facility to come back to the Government and say, "Well, we need more money now."

If that is the purpose of it I think that you gentlemen are very well advised in doing that because that will provide at least that contingency, but when you do this to private capital you are putting them out of business.

Mr. UTT. Thank you. That is all, Mr. Chairman.

The CHAIRMAN. Any further questions?

If not, again we thank you, Mr. Goodman, for coming to the committee.

Mr. GOODMAN. Thank you very much.

The CHAIRMAN. Mr. Fleming and Mr. Erickson.

Mr. Fleming and Mr. Erickson, if you will identify yourselves for our record, we will be glad to recognize you.

Mr. UTT. Mr. Chairman.

The CHAIRMAN. Yes, Mr. Utt.

Mr. UTT. While they are preparing to put on the microphone, I want to welcome both Mr. Fleming and Mr. Erickson to the committee. As you know, the Kaiser Foundation has been one of the pioneers in the field of prepaid insurance and health plans. They have been most successful in California in trying to integrate a long-standing hospital program with the medicare program.

We went part way, but I don't think we went as far as is necessary, and I do compliment the Kaiser Foundation for its work in the hospital prepayment medicare program, and now in existence some 30 years, I believe, or very close to that.

**STATEMENT OF SCOTT FLEMING, VICE PRESIDENT AND ASSOCIATE
MANAGER OF KAISER FOUNDATION HEALTH PLAN, INC.,
ACCOMPANIED BY ROBERT J. ERICKSON, LEGAL COUNSEL**

Mr. FLEMING. Yes.

The CHAIRMAN. We are pleased to have both of you with us, and you are recognized, sir.

Mr. FLEMING. Thank you, Mr. Chairman.

I wish very much to thank Congressman Utt for his kind introduction.

I am Scott Fleming, vice president and associate manager of Kaiser Foundation Health Plan. With me is Robert Erickson, legal counsel for our program. We appreciate this opportunity to discuss two problems of great significance which are presented by section 129 of the proposed "Social Security Amendments of 1967."

KAISER FOUNDATION MEDICAL CARE PROGRAM

The Kaiser Foundation medical care program is the largest of several comprehensive prepaid group-practice health care programs in the United States. Our program now serves more than 1,500,000 members—an increase of over 300,000 members since we testified before this committee in 1965, and somewhat over 5 percent of the population of the Pacific Coast States and Hawaii in which we operate.

Ours is a nonprofit, financially self-sufficient program which functions under private sponsorship and management. Similar plans serve substantial populations in New York, Detroit, Washington, D.C., Seattle, Cleveland, and elsewhere. These medical care programs represent a systematically planned and organized approach to the the provision of health care services—a significant characteristic in view of the health facility planning provisions of section 129.

OUR EXPERIENCE UNDER MEDICARE

In 1965 we expressed concern regarding the impact which the original medicare legislation—fundamentally oriented toward the insurance concept of cash payment—would have on organizations such as ours which provide health care services directly instead of acting as payers of hospital and medical care bills.

Our experience during a year of preparing to coordinate our operations with medicare and 8 months of actual operations thereunder confirm the concerns which we expressed to this committee. However, even though the amendments which then suggested were not adopted, we have—with the aid of helpful expressions in this committee's report, and through extensive work with able and conscientious personnel in the Social Security Administration—been able to resolve many problems. Continuing efforts are underway to develop constructive solutions to a number of unresolved problems.

These problems involve administrative and financial relationships and interpretation of the existing medicare law—not medical and hospital care. I can assure this committee that the medicare beneficiaries enrolled in our program—between 50,000 and 60,000 persons—have been served without disruption under a combined medicare-Kaiser Foundation health plan coverage which, for the individual beneficiary, represents a significant increase in benefits at a reduced out-of-pocket cost.

MAJOR PROBLEMS PRESENTED BY SECTION 129—FUNDING DEPRECIATION AND HEALTH CARE FACILITY PLANNING

Consistently, since 1961, the Kaiser Foundation health plan supported the basic medicare legislation because we were satisfied that,

despite the substantial difficulties which it portended for comprehensive integrated health care programs, it would meet an important social need in a reasonable and practical, even though not an optimum, manner.

Today we must register our most vigorous opposition to the provisions contained in section 129 of H.R. 5710 which relate to funding of depreciation and health facility planning.

In this connection I might mention that we are perhaps unlike many nonprofit programs because we are financially self-sufficient, although the Kaiser family and various branches of the Kaiser organization provide some seed money to get this program started. Basically most of the program has generated the funds for itself, and hence we are in the position that is not unlike Mr. Goodman who just testified, from the viewpoint of the proprietary hospitals. We are conducting an enterprise that has to be successful on its own feet, and we believe this is the sound approach to a health care enterprise whether it be nonprofit or proprietary.

We regret the necessity to oppose these provisions because we know that they are proposed and supported by conscientious and well-motivated people and organizations in the sincere belief that they represent desirable solutions to important problems. However, our organization has considerable experience in health facility planning and allocation of resources to health care facilities and services; and this experience convinces us that the funding and planning provisions of section 129 are economically unsound and socially undesirable. Thus we feel obliged to express as thoroughly as time permits, the reasons for our opposition.

FUNDING OF DEPRECIATION

If we were seeking an example of a superficially plausible economic concept which embodies serious fallacy, the concept of funding depreciation would be a leading candidate. In its simplest form funding of depreciation will involve investing capital at the rate available on the most conservative investments, such as Government bonds, and replacing the frozen capital by borrowing money at much higher rates of interest. Our experience shows that the difference between the rate at which our financially sound organization can borrow and the average rate on the type of investment appropriate for funding might approximate 2 percent—a differential which in one way or another would be reflected in the cost of health care services.

In our case, looking at actual experience from 1961 through 1966 and forecasts for 1967 through 1970—a total of 10 years—this differential applied to depreciation in our total operation would produce an additional interest cost of \$3 million. Twenty per cent of this amount, the approximate proportion applicable to the utilization of our facilities by persons over 65, would represent \$600,000. We do not think this committee intends to require us to dissipate an average of \$60,000 a year in unnecessary interest expense through legally prescribed misuse of resources, nor do we think the committee intends to compel other health care organizations to engage in comparable waste.

The problem so far discussed involves interest only; the 6 to 7 million dollars which the proposed depreciation requirement would have

us tie up in a funded reserve would be sufficient pay for a modern medical center serving some 75,000 health plan members.

The underlying issue here is the efficient use of capital. We feel confident that qualified economists familiar with problems of enterprise financing and resource allocation will regard funding of depreciation as an economically unsound approach in the circumstances facing the health care industry in the United States today—with a rapidly advancing technology, rapidly increasing personnel costs, and serious shortages of skilled health care personnel. Significant modification in the pattern of rapidly increasing health care costs can realistically be expected only through capital investment on a scale scarcely yet appreciated. Depreciation is a major source of new investment.

To take a simple example, 20 years ago a widely used hospital bed made by the Simmons Co. cost approximately \$65. A similar bed today will cost about \$150. However, we purchase patient-controlled, electrically operated beds which cost about \$500, because these beds provide more patient comfort, and greatly reduce demands upon the nursing staff for bed adjustment, with important savings in personnel time and consequently in operating costs.

Much more dramatic is the transition in scientific equipment. Twenty years ago manually operated blood testing equipment, for a medium-sized hospital laboratory, would have cost perhaps \$1,000, and, if used today in California, would involve a cost of more than \$1 per test, and inaccuracies of up to 10 percent.

Current automatic equipment for which we pay some \$30,000 permits blood tests at an average cost of approximately 50 cents, with results accurate to within about 2 percent. The most advanced equipment in existence, for which we are now negotiating, will represent an investment of some \$450,000 plus the cost of associated computers; however, we expect this installation to perform the work of 30 scarce clinical laboratory technicians, with further improved accuracy, and a reduction in the average cost per test to approximately 5 cents.

It is also appropriate to point out that the provisions on funding depreciation do not appear to authorize use of funds generated through depreciation for repayment of indebtedness—a devastating blow at the capacity of health care organizations to raise capital by borrowing from banks and other conventional sources of major financing.

Members of the committee might dismiss much of the foregoing as missing the point because the proposed legislation would not render depreciation funds unavailable for capital investment but only for “improper capital expenditures,” which brings us to the heart of the issue—health facility planning, and the problem of who determines what investments are “improper”—and by what standards.

HEALTH FACILITY PLANNING

For more than 20 years responsible observers of health care in the United States have deplored the lack of planning in the health care field and the rather haphazard development of hospitals and other health care facilities, with various governmental units, voluntary nonprofit organizations, and proprietary sponsors pursuing their individual aims in an uncoordinated manner. The resulting duplica-

tions, overlaps, and gaps have been widely condemned, and governmental and voluntary money and effort have been expended at every level in pursuit of planning.

Indeed, health facility planning was a major objective of the Hill-Burton program enacted by Congress in 1946, and during the last 10 years efforts and expenditures justified under the planning label have accelerated at a phenomenal rate. To a much greater extent than most people realize the rather unordered complement of health care facilities in the United States, which now constitutes exhibit A in support of planning, is, in fact, the product of increasingly vigorous planning efforts. But, say the advocates, heretofore planning has not had any teeth whereas H.R. 5710, by relating medicare reimbursement to compliance with State health facility plans, will give the planners effective powers of enforcement, and planning, at last, will work.

The skeptic might wonder whether disallowance of depreciation for medicare patients will produce more effective planning results than outright grants of large sums of Government money, but this query misses the most significant issues. The statutory notion that we deal with is the concept of "improper capital expenditures"—any "capital expenditure (which) * * * the State agency * * * determines * * * does not conform to the overall plan * * *"

So let us consider some basic questions related to health facility planning—

Planning by whom?

Planning for whom?

Planning of what?

The normal consequence of establishing a health facility planning program is that the planning process will, directly or indirectly, be committed to professionals in the health care field—the physicians, the hospital administrators, and others active in health care careers—that is to say, the same people who are responsible for the allegedly unsatisfactory present situation which requires more congressional support of planning.

The significant issues in planning for a more orderly and economical system of health care facilities and services are not technical issues falling within the professional competence of physicians, hospital administrators, and other persons for whom health care is a career.

The basic issues involve political, economic, and social policy which, in a governmentally sanctioned planning system, should be committed to persons representing the entire public as consumers, not providers, of health care services. The professionals can and should function as technical advisers on the many technical complexities of health care; but the only kind of governmentally sponsored planning that can be justified is planning for the consuming public, and we suggest that this will only be achieved if planning policy is controlled by representatives of the total community.

This viewpoint is not based on any lack of respect for the sincerity and dedication of health care professionals, but rather on a simple and almost inescapable human characteristic which one physician expressed to me by saying that "You can't jump out of your skin."

Among individuals who have devoted extensive careers to practicing medicine, or administering or otherwise participating in the

operation and management of hospitals and other facilities which are part of the traditional U.S. health care system, only the most remarkable can detach themselves sufficiently from their environments to have an objective and fresh perspective from which to make the policy judgments involved in health facility planning.

And now we go to the last, and in some respects the most far-reaching issue—what shall planning encompass?

To make my point briefly, I will resort to an analogy that will seem far-fetched, but with pertinence that will, I believe, be appreciated as the nature of planning in the health care field is more fully understood.

Let us look at the automobile industry in the United States with its carefully planned, highly integrated production facilities representing an advanced embodiment of industrial planning. Let us imagine that the discrete elements of an integrated automobile factory represent the highest level of current technology, with automated machines controlled by trained and experienced automobile workers.

Now let us make one further and admittedly preposterous assumption that, although each discrete element of this factory is carefully planned, the movement of raw materials and partially fabricated automobiles through the plant is unplanned and haphazard so that, for example, engine blocks are delivered to cylinder boring machines from a variety of directions at irregular intervals by a mixture of conveyances.

Ridiculous and irrelevant? We believe not, because the crucial element in health care is not the facility—no matter how modern and sophisticated—but the service of individual physicians whose professional judgments in the handling of individual patients determine how health care facilities are utilized. Planning health care facilities without planning the organization of the professional services which will control the use of the facilities closely approaches an exercise in futility.

Please let me be completely clear that we do not suggest expanding the scope of planning contemplated by H.R. 5710 to encompass planning the manner in which physicians shall organize their practices. Most physicians in the United States practice individually or in small groups in a highly individualistic fashion. We do not suggest that any arm of Government can advantageously modify this pattern of medical practice, by statute or decree, nor do we suggest that such action would be desirable even if it were practical. What we do assert is that planning of the externals—location, brick and mortar, and equipment that make up health care facilities—can only produce ineffective and disappointing results if the heart of the health care system, the professional practice of the physician—is to remain outside the jurisdiction of planning.

I speak from the viewpoint of an organization heavily engaged in planning health facilities and services to meet the needs of a large and rapidly increasing population. We know that this is a most complex and difficult subject; and we urge the committee that planning, sponsored and sanctioned by government, deserves full-scale congressional consideration on its own merits and should not become national policy through provisions which are almost incidental in H.R. 5710.

In this connection the findings of two Presidential Commissions, the existing Commission on Health Manpower and the proposed Commission on Health Facilities, should be highly relevant.

In conclusion we wish to suggest to this committee that, unless the most extensive and careful safeguards are developed, health facility planning—under governmental sponsorship, and supported by economic sanctions, has an alarming potential for perpetuating the status quo, promoting conformity and stifling innovation and diversity—a tragic prospect at a time when technological change in health care can, within the lifetime of people in this room, produce benefits now scarcely imagined, and at a time in which, in an atmosphere of freedom and flexibility, social and organizational changes and innovations in the health care field can produce public benefits dwarfing to insignificance the financial benefits claimed to be available through health facility planning provisions of H.R. 5710.

Thank you.

The CHAIRMAN. Thank you, Mr. Fleming. We appreciate having you and Mr. Erickson with us today.

Are there any questions?

Mr. UTT. Mr. Chairman.

The CHAIRMAN. Mr. Utt.

Mr. UTT. I don't know whether you read the statement of Mr. Goodman where he refers to the 70 regional planning commissions. Do they do anything toward the efficient operation of a hospital, or do they just recommend locations?

Mr. FLEMING. Well, they do various things in various places. In California there are a considerable number. To date they have not had authority to enforce their recommendations, but they do make quite extensive recommendations on the subject not only of location of new facilities, but on the operation thereof.

For example, they have been making efforts in the city of San Francisco to achieve consolidation of certain services in certain hospitals. As yet I do not think there are any very tangible results to be pointed to.

Mr. UTT. You don't think that they can resolve the analogy that you made of the automobile industry?

Mr. FLEMING. I do not think that they can. To us running an integrated program, it is fundamental that the role of the physician is primary, and we plan basically around the physician, but the general concept of planning is planning around the facility. If the physicians are willing, as in our program they are, voluntarily to come with the program and participate in the planning, then you can have a really integrated program, but if the physicians are practicing individually and looking at the facilities only as a place to take patients, you are planning with the heart of the problem outside the plant.

Mr. UTT. Thank you.

The CHAIRMAN. Any further questions?

If not, again we thank you, gentlemen.

That completes the calendar for today, and without objection, the committee will adjourn until 10 o'clock in the morning.

(Whereupon, at 1:45 p.m., the committee adjourned, to reconvene at 10 a.m., Thursday, March 9, 1967.)

PRESIDENT'S PROPOSALS FOR REVISION IN THE SOCIAL SECURITY SYSTEM

THURSDAY, MARCH 9, 1967

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met, pursuant to notice, at 10 a.m., in the committee room, Longworth House Office Building, Hon. Wilbur D. Mills (chairman) presiding.

The CHAIRMAN. The committee will please be in order.

Our first witnesses this morning are representatives of the American Nursing Home Association, Mr. Walker and Mr. Pickens, accompanied by others.

Will you please come to the witness table?

Mr. Walker, are you to make the opening statement?

STATEMENTS OF JOHN K. PICKENS, GENERAL COUNSEL, AMERICAN NURSING HOME ASSOCIATION; STEPHEN J. MORRIS, PAST PRESIDENT, CALIFORNIA NURSING HOME ASSOCIATION; CHARLES Z. WICK, PRESIDENT, UNITED CONVALESCING HOSPITALS OF LOS ANGELES; AND MARVIN SMITH, CPA, DENVER, COLO.; ACCOMPANIED BY ED WALKER, PRESIDENT, AMERICAN NURSING HOME ASSOCIATION; HAROLD SMITH, PRESIDENT, LOUISIANA NURSING HOME ASSOCIATION, AND FRANK G. ZELENKA, ASSISTANT EXECUTIVE DIRECTOR, AMERICAN NURSING HOME ASSOCIATION

Mr. WALKER. Mr. Pickens will make the opening statement.

The CHAIRMAN. Mr. Pickens. If you will identify yourself, Mr. Pickens, for our record by giving us your name, address and capacity in which you appear we will appreciate it.

STATEMENT OF JOHN K. PICKENS, GENERAL COUNSEL, AMERICAN NURSING HOME ASSOCIATION

Mr. PICKENS. Thank you, Mr. Chairman. I am the general counsel of the American Nursing Home Association. I have with me today Mr. Stephen Morris on my left, who is the past president of the California association, who will also make a statement, and on his right is Mr. Frank G. Zelenka, assistant executive director, American Nursing Home Association. On my right I have Mr. Ed Walker, the president of the American Nursing Home Association and on his right is Mr. Harold Smith, the president of the Louisiana Nursing Home Association.

The CHAIRMAN. You do not have at the table Mr. Wick or Mr. Smith?

Mr. PICKENS. Mr. Wick and Mr. Marvin Smith, Mr. Chairman, will give their statements after Mr. Morris and myself.

The CHAIRMAN. All right. Are they at the table?

Mr. PICKENS. No, they are not at the table; no, sir.

The CHAIRMAN. I didn't think so. You are recognized, sir.

Mr. PICKENS. Thank you, Mr. Chairman.

Mr. Chairman and members of this committee, I do have a short statement attached to which are copies of correspondence with Secretary and Under Secretary of the Department of Health, Education, and Welfare as well as a small random sample of correspondence with the Governors of a few States. Copies of this have been made available to members of the committee so I will try to be as brief as possible.

My name is John K. Pickens. I am a partner in the firm of Dawson, Griffin, Pickens & Riddell of Washington, D.C., and I have been general counsel of the American Nursing Home Association for the past 6 years. I appreciate the opportunity to appear before you to discuss, along with other representatives of the association, several problems involving titles XVIII and XIX of the Social Security Act as well as those involved in the bill H.R. 5710.

CORRESPONDENCE WITH HEW

On January 16, 1967, I sent a seven-page letter to Secretary Gardner in which we disputed the authority of the Secretary to issue regulations under the present title XIX fixing standards of professional care for public and private institutions for recipients of old-age assistance. A copy of this letter was forwarded to each member of this committee.

Under Secretary Wilbur Cohen answered this letter in part on February 25, 1967, and I understand a copy of his response has been made a part of the record. I would like to have my original letter of January 16, 1967, and my response of March 8, 1967, made part of the record at the conclusion of the testimony of the witnesses for the American Nursing Home Association.

The CHAIRMAN. In order to have a complete picture—I am not certain just where in the record this letter from under Secretary Wilbur Cohen may have been placed, the one you referred to—it hasn't been received yet I understand, so I think it would be better for the record if all of this correspondence could be placed together in the record, either in connection with your testimony or Mr. Cohen's testimony or in between somewhere, so we will let the staff work with you in the placement of it in the record. (See p. 355 and p. 796.)

Without objection, they will all go in.

Mr. PICKENS. Thank you, Mr. Chairman. Whatever they decide, of course, will be all right with us.

TITLE XIX

Last July, the Department of Health, Education, and Welfare issued so-called supplement D which is in effect regulations and standards governing nursing homes. In section 5141, page 2, the Department purports to define a "skilled nursing home" as a facility which

is licensed by the State and is or will be by January 1, 1968, qualified as an "extended care facility" under title XVIII.

In order to qualify as an extended care facility, it is necessary that a nursing home meet title XVIII regulations which are called conditions of participation and contain some 41 pages.

It is the position of the American Nursing Home Association that the Secretary is without authority to fix standards of care for public or private institutions caring for the indigent under title XIX. Section 1902(a) (9) of the Social Security Act—Public Law 89-97—provides that a State plan for medical assistance must "provide for the establishment or designation of a state authority or authorities which shall be responsible for establishing and maintaining standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services."

Section 1902(a) (22) provides the plan must—

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B)—

And this is the important part—

the standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the state authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with state health agencies and state vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D)—

And this is another important part—

other standards and methods that the state will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality.

Sections 1902(a) (1) through (22) and particularly (a) (9) and (22) make it crystal clear that title XIX places the authority in the State agency administering title XIX to establish and maintain standards of care in private and public institutions.

There was no intention to give this authority to the Secretary. House Report 213, page 66, and Senate Report 404, part I, page 75, both of 89th Congress, first session, makes it abundantly clear that the new sections to title XIX give no authority to the Department of Health, Education, and Welfare with respect to the content of such standards and methods.

The Senate adopted an amendment which was 1902(a) (9) (B), and which reads as follows:

(B) provide that, after June 30, 1967, the requirements under the standards established and maintained by such authority or authorities shall include any requirements which may be contained in standards established by the Secretary relating to protection against fire and other hazards to the health and safety of individuals in such private or public institutions; . . .

Senate Report 404, part I, page 75, states the following in regard to this amendment:

The committee's bill—

Meaning the Senate Finance Committee—

would add a requirement that the state plan include a description of the standards, methods and administrative arrangements which affect quality of medical care that a state will use in administering medical assistance.

The next sentence is the most important.

The amendment would give no authority to the Department of Health, Education, and Welfare with respect to the content of such standards and methods. In this respect it is somewhat analogous to the requirement, which has been in the public assistance titles since 1950 and which is included in the new Title XIX, requiring states to have an authority or authorities responsible for establishing and maintaining standards for private or public institutions in which recipients may receive care or services.

The report continues on the next page as follows:

Current provisions of law requiring states to have an agency or agencies responsible for establishing and maintaining standards for the types of institutions included under the state plan have been continued under the bill. Your committee expects that these provisions will be used to bring about progressive improvement in the level of institutional care and services provided to recipients of medical assistance. Standards of care in many medical institutions are not now at a satisfactory level and it is hoped that current standards applicable to medical institutions will be improved by the state's standard-setting agency and that these standards will be enforced by the appropriate state body.

Thus the Senate report makes it very clear that Senate Amendment 254 was an invasion of the State prerogative to set standards only to the extent that the Secretary was allowed to require certain standards relating to protection against fire and other hazards to the health and safety to individuals in such private or public institutions.

The conferees, on the part of the House, from this very committee, insisted on striking this amendment from the Senate-passed bill. The conference report recommended that the Senate recede from this amendment which it did when it passed the conference report, or when it adopted the Senate report.

Accordingly, it is abundantly clear that Congress did not intend to give the Secretary even meager authority to fix standards relative to fire and safety.

The Department now contends that its authority to fix standards derives from its inherent authority to define the term "skilled nursing home services" in section 1905(a)(4) and the miscellaneous term found in section 1905(a)(15) which states that medical assistance means, among other things, "(15) any other medical care, and any other type of remedial care recommended under state law, specified by the Secretary."

The term "skilled nursing home service" first came into the Social Security Act in 1960 and for 6 years the Department has found it unnecessary to further define "skilled nursing home service."

We recognize that every administrative agency has a certain limited power of interpretation for definition of commonly recognized words. We concede the Department would have the authority to state that in order to receive Federal funds for nursing home care such care would have to include some supporting nursing service. Beyond interpreting or defining this term, the Secretary has no authority inherent or otherwise.

The Secretary, in fact, has gone far beyond the field of definition and interpretation and has written standards of care for public and private institutions. These standards are contained in 41 pages in title XVIII, Conditions for Participation of Extended Care Facilities, and 261 pages of supplement D, most of which are on both sides of the page, making a total of over 500 pages.

I might say I don't mean to mislead the committee. Not all of these pages in supplement D relate to nursing homes. I would say approximately a fourth of them do.

While it is true that the Secretary can provide that nursing homes must provide some skilled nursing services, it does not give him the authority, under the guise of defining such term, the right to issue standards covering physical environment, medical staff, nursing departments, dietary departments, medical record departments, pharmacies, laboratories, radiology, medical library, complimentary departments, out-patient departments, emergency departments, social departments, and utilization review departments, but this is exactly what he has done by adopting the conditions for participation in title XVIII.

In my reply to Secretary Cohen on March 8, I used the homey analogy of the term "restaurant" contained in a statute. Of course this was a hypothetical case. In that instance the Administrator could define restaurant as a place where food was served to the public; however, under the guise of interpreting the word "restaurant," such Administrator could not provide for the number and qualifications required for cooks, the qualifications and number of waitresses, the size, location, and number of tables, the construction of the dining room and kitchen, the inspection of the kitchen and dining area, health examination for the employees, and the like.

We believe it to be quite clear that Congress intended that the establishment and maintenance of standards was delegated to the States and that the Secretary was specifically prohibited from issuing such standards under the guise of interpreting the "skilled nursing home services" under 1905(a)(4).

SECTION 1905(A)(15)—OTHER MEDICAL CARE, OTHER TYPES OF REMEDIAL CARE RECOGNIZED UNDER STATE LAW SPECIFIED BY THE SECRETARY

Section 1905(a)(15) provides that the term "medical assistance" also includes the cost of, among other things, "any other medical care, and any other type of remedial care recognized under state law specified by the Secretary."

Primarily because subsection (15) comes at the end of the list of what care will be paid for under the term "medical assistance," the Department now contends that this includes all "skilled nursing home services" and that the phrase "recognized under State law, specified by the Secretary" gives the Department the authority to issue standards or regulations for private or public institutions under which recipients of medical assistance under the State plan may receive care.

This is the first time that the Department has made this contention. In fact, on pages 9 and 10 of section 5141 of supplement D issued in July 1966, it defines this very term as including the following items "in those states in which they are recognized under state law and under the circumstances, and to the extent to which they are so recognized; (a) transportation, (b) family services, (c) whole blood, (d) services of Christian Science Practitioners, (e) services provided in Christian Science Sanatoria and (f) Skilled Nursing Home Services, as defined in (a)-5141, Item 4, provided to patients under 21 years of age."

In July of 1966, the Department did not contend that it had authority, under section 1905(a) (15) to define "other medical care" or "other types of remedial care recognized under State law" except to a very limited extent and except to cover "skilled nursing home services" to patients under 21 years of age.

It is submitted that the literal language of 1905(a) (15) precludes the Secretary from specifying any type of medical assistance other than that recognized under State law. This, certainly, would give him no authority to issue regulations or standards governing care in private or public institutions in any State.

SUPPLEMENTATION

The Department, in defining requirements for State plans under supplement D (secs. 5320 and 5330), provides that supplementary payments to providers of services are outlawed or prohibited. These regulations accomplish this by providing, in part:

D-5320. Requirements for State Plan.

A state plan for medical assistance must provide that:

1. Fee structures will be established which are designed to enlist participation of a sufficient number of providers of service in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population.

The next one is the important one.

2. Participation in the program will be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structures.

D-5330. Criteria for the Administration of the Plan.

3. The State Agency requires compliance by providers of service with the fee structures as a condition of participation. The state agency:

- a. Establishes written policies prohibiting billing at higher rates or in additional amounts: . . .

In adopting these regulations, 5320 and 5330, the Secretary relies on sections 1902(a) (1), (4), (13), and (19). It is the position of our association that not one of these sections, individually or all of them collectively, give the Secretary such authority.

In enacting title XIX, Congress did not adopt any policy against supplementation of State payments to nursing homes or other providers of service covering the cost of care for indigent patients. Subsequent to the issuance of supplement D in July of 1966, the Secretary has given the States 1 year in which to do away with supplementary payments.

In our several discussions with representatives of the Department, these representatives have taken the position that supplementary payments encourage smaller indigent payments by the State than would otherwise be paid. They further take the position that all indigent patients should receive the same care.

The Department is inconsistent in its argument against supplementation. It proposes to allow supplementation to some extent under title XVIII. Under title XVIII the Government will pay the cost of care to providers of services for the cost of accommodations in a semiprivate room, two to four beds.

However, they will allow the friends or family of the patient, or the patient, to pay a supplementary amount in order to have accommoda-

tions in a private room. They will also allow supplementary payments to provide patients with a television set, radio, or similar services.

It is the position of our association that the Secretary has no authority to deal with the problem of supplementation. This is for the Congress. It is our further position that if Congress desires to do away with supplementation it is only just and reasonable that these payments be phased out over a period of from 3 to 5 years.

Approximately 21 States allow supplementary payments in one form or another. In many States, such as Florida, where State payment is only \$100 a month—that is for the care of indigent patients—but additional supplementary payments of \$200 a month are allowed for a total of \$300 a month, no nursing home could afford to take welfare patients if the \$100 a month were not supplemented.

Representatives of HEW testified 2 years ago, during hearings on Public Law 89-97, that most welfare payments were below cost. Many State legislatures have not, as yet, increased their payments for the care of indigents to provide for rising costs.

On February 1 of this year, nursing homes were covered under the Fair Labor Standards Act for the first time. Since nursing homes receive no jurisdictional exemption under the minimum wage law, all nursing homes are now subject to it.

I might add here parenthetically that this association did not oppose covering nursing homes under the minimum wage law.

In most Southern States complying with the minimum wage law will require a 30-percent increase in the payment of wages for unskilled employees; namely, kitchen and laundry help as well as aids and orderlies. The increase in wages in these classifications always result in a forced increase of wages among the professional help such as licensed, practical, or vocational nurses, and registered nurses.

The increase in coverage of nursing home workers has caused the increase of State minimum wages in the northern and western sections of the country, which were already higher in many areas than Federal wages, and proposals in other States of an increase later this year.

Nursing homes were already under the impact of increased costs in attempting to get ready for medicare and title XIX. All of these factors make it virtually impossible for the States allowing supplementation to pick up the additional amount of money necessary to do away with supplementation.

In South Carolina, as an example, nursing homes are having a difficult time getting any increase in the rate of State payments in order to meet the cost of increased wages brought about by the minimum wage law. South Carolina has a present State monthly rate of \$175 and nursing homes are permitted to accept supplementary payments of up to \$250 per month.

It is almost impossible for the nursing homes of South Carolina to obtain any additional amount from the State legislature this year to cover increased cost to provide for the elimination of supplementary payments. Of the 74 licensed nursing homes in South Carolina, 50 are certified as extended care facilities. This is a far higher ratio of certified extended care facilities than in most States.

I mention this to show that South Carolina was picked because it has a high percentage of extended care facilities. The problems

faced by South Carolina are repeated in every one of the States presently allowing supplementary payments.

If it is the view of the Congress that supplementation should be eliminated, then in all fairness to the patients involved, the State legislatures, and the nursing homes, supplementary payments should be phased out over a period of 3 to 5 years.

In my letter of March 8 to Under Secretary Wilbur Cohen, I again raised this problem; however, I do not wish to leave the impression that in the the State of Florida, as an example, if supplementation were eliminated the State would have to find the funds for the total amount of the \$200 supplementary payments now allowed. If Florida implemented title XIX, the Federal Government would pick up part of this \$200 supplementary payment.

ESTABLISHING OF STANDARDS UNDER TITLE XVIII VERSUS TITLE XIX

Section 1861(j) (10) specifically gives the Secretary the authority to establish standards and issue regulations concerning extended care facilities under title XVIII. Other sections of title XVIII provide that in promulgating regulations the Secretary should consult with national organizations concerned in this matter.

On August 6, 1965, the then president of the American Nursing Home Association, Mr. Roy J. McDonald wrote to the Secretary in which he offered the complete cooperation of the association in implementing Public Law 89-97.

In that letter he suggested the names of several nursing home administrators. The American Nursing Home Association cooperated fully and worked with the five task forces that developed the conditions of participation and other regulations issued by the Secretary under title XVIII. Copies of this letter have been supplied to members of the committee.

The only two problems with which the association was not satisfied with the solution determined by the Secretary were (1) the refusal to classify on the basis of ability, experience, and training, waived licensed practical and vocational nurses and (2) the principles of reimbursement.

The procedures and regulations under title XVIII are in sharp contrast to those under title XIX. There is no authority under title XIX for the Secretary to establish or promulgate regulations concerning nursing homes. Likewise, there are no provisions under title XIX requiring the Secretary to consult with national organizations on the matter of standards since this was left to the States.

Accordingly, the American Nursing Home Association was not consulted in connection with the proposed provisions of supplement D, nor did the Bureau of Family Services have any representative from the association or any nursing home administrator or other personnel connected with the nursing home field on its advisory board.

Neither was there any group or body similar to the Health Insurance Benefits Advisory Council—on which were representatives of all the health professions involved—consulted about supplement D or any other regulations which have been promulgated by the Secretary in regard to title XIX. This is contrary to the letter and spirit of the Administrative Procedure Act.

The association is in receipt of a copy of a letter dated March 1, 1967, from Under Secretary Cohen to its president, Ed Walker, in which Mr. Cohen enclosed a revision of supplement D which the Department proposes to promulgate.

We believe that the Department is wise in moving backward the effective date of its proposals under January 1, 1969. Likewise, we believe these new proposed standards to be somewhat more realistic.

However, if the Secretary does not possess the authority to establish standards—which was clearly left to the States—it would follow that he does not have the authority to promulgate the standards which they now propose. I might say to the committee that these standards are attached to this letter dated March 1, 1967, to Mr. Walker from Mr. Cohen, a copy of which each member has.

CHANGE IN DEFINITION OF "SPELL OF ILLNESS"

Section 1861(a) of the Medicare Act defines "spell of illness" as beginning on the day an individual enters a hospital and is furnished hospital and/or nursing home care and leaves the facility plus 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital or an extended care facility. This definition poses two basic problems.

Assume that a patient uses his full 90 days in a hospital and his full 100 days in a nursing home as a medicare beneficiary. He then requires continued nursing home care either as a private pay patient or as a patient under title XIX or some other State program. Many have assumed that after 60 days a new "spell of illness" would start and he would again become eligible for care under medicare.

Under HEW's interpretation of section 1861 (a) and (b), the phrase "ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of an extended care facility" means not simply that he is not in an extended care facility under medicare, but that he is not physically in any facility, extended care facility or nursing home at all, for 60 consecutive days. He could still be receiving his 100 home health care visits under part A and an additional 100 home health care visits under part B—supplementary insurance program—and these, of course, are on an annual basis.

This interpretation means that the patient has to have, in effect, a 60-day "spell of health" if he is ever again to qualify for the medicare benefits of hospital and nursing home care. This is not only discriminatory, but also unrealistic when one considers the general health of the aged who are covered by the medicare program.

If a person can be transferred to his home and receive his 200 annual home health visits (the total allowed under parts A and B) his 60-day "spell of health" begins although he is not really well.

INTERPRETATION OF OTHERS DIFFER FROM THAT OF HEW

The words "hospital" and "extended care facility" are terms of art under the law. Therefore, a more respectable argument can be made for the proposition that if a facility does not meet the eligibility test, it is not an "extended care facility."

If this interpretation of "spell of illness" is correct, a person could be moved—to another nursing home—not a qualifying extended care facility—either as a private pay or State-supported patient, and begin his so-called "spell of health" but he could not be kept in a medicare approved "extended care facility." This would make very little sense.

The Department's present interpretation could be taken care of by adding the following phrase to section 1861(a)(2) "under the provisions of title XVIII" so that this section would read as follows:

(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of an extended care facility under the provisions of Title XVIII.

And I believe this is what the Congress intended.

The second problem involves the patient who almost exhausts, or does exhaust his hospital and nursing home benefits during a single "spell of illness" and then, on his last day in the nursing home or on his return to his own home, suffers a broken leg or hip or some other illness which has no direct connection with his previous infirmity.

At present, he would be ineligible for additional hospital benefits under medicare. The phrase of the amendment "for the same illness" added to the suggested amendment just read would correct this situation.

It is not clear, from the legislative history, whether Congress wanted to provide against this type of hardship or not. In any event, this hardship would be eliminated by the addition of the phrase as shown above. It may be that Congress did not intend to cover this situation, but we feel rather certain that Congress did intend to cover the first situation because I have heard many say that under the medicare program when they exhausted their medicare benefits they would go over under title XIX and then they could again pick up their medicare benefits after the 60 days on title XIX, but under the Department's interpretation this would not be so.

I am sorry I have taken so long, Mr. Chairman. I do appreciate the privilege of being here and I would be glad to answer any questions that I can.

(The information referred to in the statement follows:)

AMERICAN NURSING HOME ASSOCIATION,
Washington, D.C., August 6, 1965.

HON. JOHN W. GARDNER,
Secretary of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. SECRETARY: As you no doubt know, the American Nursing Home Association worked closely with the House Ways and Means Committee and the Senate Finance Committee to improve H.R. 6675.

We suggested many amendments which were not accepted but which we are confident that you will eventually provide for the rules and regulations which will be promulgated pursuant to the Medicare Act.

Among these was the requirement that an "extended care facility"—

(1) be a fire resistant structure, be sprinkled and have a fire detection system;

(2) have a disaster plan; and

(3) maintain a planned program of nursing care, including a plan for each individual patient, written nursing procedures, a patient restoration program and a continuing program of in-service training.

As President of the Association, I would like to offer you an Advisory Group of Nursing Home Administrators to assist you and your aides in the development and formulation of regulations regarding nursing homes and related facilities.

As you can see, the suggested group are outstanding nursing home administrators—half of which are from nonprofit homes—and distributed geographically throughout the United States.

Dr. Carl E. Becker—Administrator of the Lincoln Lutheran Home of Racine, Wisconsin and a member of the Board of Directors of the some 220 Lutheran Homes throughout the United States, as well as a director of the Good Samaritan Society.

Mr. Richard Snow—Past President of the New Mexico Nursing Home Association, Administrator of the New Modern Presbyterian Nursing Home Center in Clovis, New Mexico.

Sister Margaret Jane—Administrator of Ozanam Nursing Home, 1812 Yakima Avenue; Tacoma, Washington and a leader in the Washington State Nursing Home Association.

Mrs. Peggy Savage—A Registered Nurse (also with a M.S. Degree) of Knoxville, Tennessee. She is Administrator of Hillcrest Medical Nursing Center (owned and operated by Knox County).

Mr. Sam Sparks—of Beaumont, Texas. He is an Administrator of The Schlessinger Home. He has operated nonprofit as well as proprietary facilities.

Mr. Alton Barlow—of Canton, New York. Past President of the American Nursing Home Association, a former hospital administrator and an owner and operator of three modern nursing homes in upstate New York.

Mr. David Mosher—of St. Petersburg, Florida. Past President of the Florida Nursing Home Association and an owner and administrator of three new modern nursing homes in St. Petersburg.

Mr. Ed Walker—of Miami, Oklahoma. President of the Oklahoma Nursing Home Association, a nursing home owner and administrator, as well as a registered Pharmacist.

Mrs. Edith Chance—of Fayetteville, North Carolina. Past President of the North Carolina Nursing Home Association, a Registered Nurse and a nursing home owner and administrator.

Mr. Robert Harberson—of Sacramento, California. Executive Director of the California Nursing Home Association.

Mrs. Eleanor Baird—of New Milford, Connecticut. She is a medical social worker, Treasurer of the Connecticut Nursing Home Association, and administrator of the Twin Pines Nursing Home.

In addition, you may feel free to call upon our Executive Director, Mr. Alfred Ercolano, 1101 17th St., N.W., Washington, D.C., or our General Counsel, Mr. John K. Pickens, 731 Washington Building, Washington, D. C. (393-5330) who is very conversant with the Medicare Act and its legislative history.

I do not know what procedure is proposed. I know that many agencies publish their proposed rules and regulations and allow comments from the general public or interested parties for a period of 60 days before such rules are finalized.

In view of the role of the Health Insurance Advisory Council I am certain that a procedure somewhat like that under the Administrative Procedure Act is not required to be followed. However, I believe that an Advisory Committee of Nursing Home Administrators could be helpful, among other ways, in reviewing the proposed rules before and after their consideration by the Health Insurance Advisory Council.

If we can be of help to you in any way, please feel free to call upon us.

Very truly yours,

ROY J. McDONALD,
President, American Nursing Home Association.

DAWSON, GRIFFIN, PICKENS & RIDDELL,
Washington, D.C., January 16, 1967.

HON. JOHN GARDNER,
*Secretary, Department of Health, Education, and Welfare,
Washington, D.C.*

MY DEAR MR. SECRETARY: I am writing you on behalf of, and as General Counsel of, the American Nursing Home Association in connection with the Regulations issued by your Department under Title XIX of the Social Security Act, as amended (Public Law 89-97). These Regulations are commonly referred to as Supplement D (Handbook of Public Assistance Administration) and were issued June 17, 1966.

While they purport to be instructions to the Welfare Commissioners of the various states (or other agency designated pursuant to Title XIX by the Governor as the Agency responsible for the development and administration of the "State Plan") they are nothing more or less than detailed regulations and standards for nursing homes which wish to participate in Title XIX. In fact, the Commissioner of the Bureau of Family Services and other representatives of your department have taken the position that they are nursing home regulations.

The Department at D-5141, p. 2, purports to define a "skilled nursing home" as follows:

"4.1 Skilled Nursing Home

"A 'skilled nursing home' is defined as a facility, or a distinct part of a facility, which (a) is licensed, or formally approved, as a nursing home by an officially designated State standard-setting authority and, effective January 1, 1967, (b) *is qualified to participate as an extended care facility under Title XVIII of the Social Security Act*; or is determined currently to meet the requirements for such participation; except that clause (b) shall not become effective until January 1, 1968 with respect to facilities which do not currently meet the requirements of clause (b) but which show reasonable expectation of meeting the requirements of clause (b) by January 1, 1968."

In using part (b) above as a device or vehicle, specifically, requiring compliance with conditions of participation under Title XVIII, your department has undertaken to write detailed regulations for Title XIX and in doing so has usurped the authority Congress specifically stated should be left to the states in formulating "state plans."

The term "nursing home service" has been in the Social Security Act since 1960 (Public Law 86-778) and has been re-enacted by the Congress several times. The Department of Health, Education, and Welfare has never seized on it as providing any authority to establish standards of care in nursing homes. Congress defined "extended care services" and "extended care facility" in great detail in subsections 1861 (h) and (j) of Title XVIII, whereas the term "nursing home service" remained unchanged. If Congress had wanted a "skilled nursing home" under Title XIX to be the same as an "extended care facility" under Title XVIII it would have so provided. Although Title XIX is a new title, the specific language found therein as the same language previously found in the various prior Titles. Thus, in effect, what the Congress has done is to reenact this language several times without changing the term "skilled nursing home service" nor at any time during these reenactments did the Congress indicate any intention to change or expand its meaning. Likewise your department administered the term "skilled nursing home service" through all these reenactments without further definition. If Congress had intended that your Department be given complete rule making authority under Title XIX as is provided in Title XVIII, the Congress would have also specifically included such authority in Title XIX. In fact, it provided the very opposite. The Congress provided the very opposite in such strong language that it is difficult to understand how the Department could choose to ignore it.

Section 1902(a) (9) provides that "A State Plan for medical assistance must:"

"provide for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services."

This provision clearly gives such authority to the State and precludes its exercise by your department. This section was amended by the Senate Finance Committee and adopted as amended. Although the language of this section is clear and unambiguous, the Report of the Senate Finance Committee (Calendar No. 389, 89th Congress, 1st Session, Report 404, part 1, page 75) *galvanizes* the words in Section 1902(a) (9). It states as follows:

"The committee's bill would add a requirement that the State plan include a description of the standards, methods, and administrative arrangements which affect quality of medical care that a State will use in administering medical assistance. *This amendment would give no authority to the Department of Health, Education and Welfare with respect to the content of such standards and methods.** In this respect it is somewhat analogous to the requirement, which has been in the public assistance titles since 1950 and which is included in the new Title XIX, requiring States to have an authority or authorities responsible for establishing and maintaining stand-

*Italics added for emphasis in each instance herein.

ards for private or public institutions in which recipients may receive care or services."

The Report continues on the next page as follows :

"Current provisions of law requiring States to have an agency or agencies responsible for establishing and maintaining standards for the types of institutions included under the State plan have been continued under the bill. Your committee expects that these provisions will be used to bring about progressive improvement in the level of institutional care and services provided to recipients of medical assistance. Standards of care in many medical institutions are not now at a satisfactory level and it is hoped that current standards applicable to medical institutions will be improved by the State's standard-setting agency and that these standards will be enforced by the appropriate State body."

The identical language is contained in the Report of the House Ways and Means Committee on H.R. 6675 (89th Congress, 1st Session, House Report No. 213, p. 66). If regulations in regard to standards under Title XIX are left to the states and your Department is precluded from setting standards, the incorporation by reference of standards tailored for an entirely different program (Title XVIII) does not validate this otherwise void action.

Of particular significance is the fact that the Senate Finance Committee attempted to give you limited authority to issue fire and safety regulations after June 30, 1967. Even this failed to pass. That Committee added an amendment (Subsection 1902(a) (9) (B), Senate Numbered Amendment No. 254) to Section 1902(a) (9) which was as follows :

*"(B) provide that, after June 30, 1967, the requirements under the standards established and maintained by such authority or authorities shall include any requirements which may be contained in standards established by the Secretary relating to protection against fire and other hazards to the health and safety of individuals in such private or public institutions ; ***".*

The Senate Finance Committee Report has the following to say in regard to this amendment :

"The committee also added an amendment to require that, after June 30, 1967, private and public medical institutions must meet standards (which may be in addition to the standards prescribed by the State) relating to protection against fire and other hazards to the health and safety of individuals, which are established by the Secretary of Health, Education, and Welfare. The committee assumes that the standards prescribed by many States at the present time will meet or exceed those prescribed by the Secretary."

However, the Senate-House Conference Committee receded from this amendment and the Senate adopted the Conference Report (89th Congress, 1st Session, House Report 682—Senate Numbered Amendment No. 254 at p. 50-51). There could be no clearer indication than this that the Congress advisedly refused to give you any authority to set any federal standards whatsoever under Title XIX.

Supplement D purports to set forth all types of criteria for the administration of state plans. This field is clearly left to the states. The drafters of Supplement D have deluded themselves by quoting parts of subsections of Title XIX out of context (in the Supplement) which entirely distorts the meaning of the Title.

Such Section 1902(a) (4) states that a state plan must :

"(4) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office and compensation of any individual employed in accordance with such methods, and including provisions for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan."

This subsection (4) is quoted throughout Supplement D (See D-5000) as follows :

*"(4) provide such methods of administration * * * as are found by the Secretary to be necessary for the proper and efficient operation of the plan ; * * *".*

The difference between the original subsection (4) and the emasculated version is considerable. The Senate Finance Committee Report explains this subsection as follows :

"The bill contains a provision found in the other public assistance titles of the Social Security Act that the State plan must include such methods of

administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan, with the addition of the requirement that such methods must include provisions for utilization of professional medical personnel in the administration of the plan. It is important that State utilize a sufficient number of trained and qualified personnel in the administration of the program including both medical and other professional staff."

The entire scheme of Title XIX is to define specifically and to limit sharply your powers to issue regulations implementing that Title. The Congress was very solicitous of the powers of the states as demonstrated throughout the language of the Title as well as the Senate and House Reports. Its scheme is diametrically opposed to that of Title XVIII in this regard.

Subsection 1902(a) (22) reiterates and further supports the intention of Congress that the States and not the Department of Health, Education, and Welfare were to fix standards for hospitals and nursing homes, among other agencies.

That section provides:

"(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) *the standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards*, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) *other standards or methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality.*"

The report of the Senate Special Committee on Aging (89th Congress, 2d Session, Report No. 1073—Development in Aging, 1965) states on page 4, footnote 1, that "An extended care facility is one which provides post acute convalescent care immediately following hospitalization. The term 'extended care facility' *should not be considered as referring to nursing homes in general.*" Subsection 1902(a) (21) provides that if the State Plan includes medical assistance for those over 65 years of age in public institutions for mental diseases, it must show that the state is making satisfactory progress toward developing and implementing a comprehensive mental health program including the utilization of "Community mental health centers, *nursing homes* and other alternatives to care in public institutions for mental diseases." I call your attention to the use of the word "nursing home" and the absence of the use of the word "extended care facility."

A 1961 survey by the Public Health Service entitled "Characteristics of Nursing Homes and Related Facilities" states on page 18 as follows:

"The term 'nursing home' has a rather general connotation in the licensure laws of many States. Depending on the licensure designation in the various States, nursing homes may provide comprehensive nursing care, limited nursing care, or simply residential care. However, the majority of the 11,251 nursing or convalescent homes reported in the study provide skilled nursing care as their primary function (see table 5). About one-sixth of the facilities (16.8 percent) have personal care as their primary function. Only 127 'nursing home' facilities were reported as primarily residential in nature."

TABLE 5.—*Type of care provided in nursing home, 1961*¹

Primary type of care provided	Homes		Beds	
	Number	Percent	Number	Percent
Total reported.....	11,251	100.0	353,285	100.0
Skilled nursing care.....	9,235	82.1	304,863	86.3
Personal care with skilled nursing.....	539	4.8	18,539	5.2
Personal care without skilled nursing.....	1,350	12.0	25,337	7.2
Residential care with skilled nursing.....	54	.5	3,139	.9
Residential care without skilled nursing.....	73	.6	1,407	.4

¹ Excludes nursing home units in hospitals. See also "A Comparative Study of 40 Nursing Homes—Their Design and Use," Public Health Service Publication 930-0-17 (1965), pp. 4 and 5.

Under the guise of issuing regulations, your representatives in Supplement D purport to outlaw all supplementation or supplementary payments to nursing homes in any form within one year. One-third to one-half of the States allow supplementary payments by the family or friends in some form. In states where welfare payments are \$100 to \$150 a month—without supplementary payments the better nursing homes could not afford to take welfare patients. We were told by your representatives that since every state legislature would meet in 1967, this provision was to serve notice on state legislatures in states having low payments that they have to raise their welfare payments this year since supplementary payments would be outlawed after January 1, 1968.

These people know not what they propose. Congress held no hearings on outlawing supplementation. Neither the Senate nor House committees concerned made any proposal touching on supplementation. Congress did outlaw family responsibility laws and similar practices. It had ample opportunity to outlaw supplementation. Had it done so, I am certain it would have not taken the seemingly cavalier and calloused attitude which your representatives apparently have. They have made no provision for the patient or the nursing home in the event the State Legislature does not raise its state welfare rates. If these invalid regulations remain in force, many welfare patients will go without nursing home care and many nursing homes will deteriorate or cease to operate. Your representatives have attempted by regulation to legislate in a field from which Congress intentionally excluded them and made no attempt to legislate itself.

Representatives of the American Nursing Home Association have discussed with representatives of your Department in great detail the lack of authority for what the Department has done. We have attempted to cooperate in every way all without avail.

We wish to give you an opportunity to rescind Supplement D before taking further action. However, if Supplement D is not rescinded in the immediate future or its effective date not suspended indefinitely, we will be required to comply with the mandate of the Association and commence appropriate action in the United States District Court to enjoin permanently the enforcement of Supplement D or any part thereof.

Respectfully yours,

JOHN K. PICKENS,
General Counsel, American Nursing Home Association.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., February 25, 1967.

Mr. JOHN K. PICKENS,
*General Counsel, American Nursing Home Association,
Washington Building, Washington, D.C.*

DEAR MR. PICKENS: This is in further reply to your thoughtful letter of January 16, 1967, regarding the definition of "skilled nursing home" for purposes of State medical assistance programs under title XIX of the Social Security Act.

As was indicated in our discussion on February 2 with you and officials of the American Nursing Home Association, we are giving further study to the qualifications which skilled nursing homes must have in order to participate in programs under title XIX, and we will be in touch with you and the Association in the very near future. In response to your letter, however, we would like to make known our views that the Department has clear legal authority to establish a definition of "skilled nursing home," and that the issues you have raised are largely matters of policy—which we are considering—and not of law.

To begin, section 1905(a) of the Social Security Act deals with the term "medical assistance," and sets forth 15 types of care and services which are included in that term. The fourth item is "skilled nursing home" services. It seems clear as a matter of legal principle—and apparently you agreed at the meeting on February 2—that, when such terms appear in a Federal statute without further elaboration, the Federal officials charged with administration of the law have the authority and responsibility for interpreting and explaining the meaning to be given to the bare words of the statute in the light of the statutory purposes.

In using the words "skilled nursing home," the Congress obviously was not referring to the full range of institutions which are licensed or otherwise regarded

as nursing homes. Moreover, these words must be related to the objective of title XIX to assure services of high quality. Certainly, all facilities which are primarily of a domiciliary nature must be excluded from the medical assistance program, and only those medical institutions which provide skilled nursing services can be included as skilled nursing homes.

A Federal definition must be applicable nationwide. It cannot call for good care in one State and deficient care in another. The Department is not obliged to accept each State's definition and thus be bound to the least common denominator.

The term, "medical assistance for the aged," in titles I and XVI (section 6(b) and 1605(b) of the Social Security Act) includes "skilled nursing-home services," but then includes as a final catch-all, "any other medical care or remedial care recognized under State law." There was little point in developing a limiting Federal definition of skilled nursing home services under these titles,—although there was authority to do so,—since the State would still be free to include nursing home services of lesser quality if recognized under State law. By contrast, the definition of "medical assistance" under title XIX of the Social Security Act sets forth various items of medical care, including "skilled nursing home services," and then includes as the catch-all "any other medical care, and any other type of remedial care recognized under States law, *specified by the Secretary*." (Section 1905(a)(15) of the Social Security Act.) Thus, it became clear that in furtherance of the statutory objective of high quality care the Secretary was not expected to accept medical care for matching under title XIX merely because it was recognized under State law. This in turn made it meaningful for the Federal officials to define the various types of care specifically set forth in the definition of "medical assistance." In short, the statutory pattern and purposes of title XIX are different in significant respects from those of titles I and XVI, with the result that the words "skilled nursing home" as they appear in title XIX require definition, as the same words in the other titles do not.

Skilled nursing home services are one of the five kinds of services that, effective July 1, 1967, must be included under State medical assistance plans. (Section 1902(a)(13)(A) of the Act.) This gives added reason for Federal definition of the term. The inclusion of these services reflects in part the relationship between title XIX and title XVIII of the Social Security Act, which were enacted together. When payments for extended care services under title XVIII cease after 100 days but need for such care continues, and the patient must then look to title XIX for payment, it is important that the latter program include sufficient facilities offering the skilled nursing services that are required.

You point out that title XVIII contains a detailed definition of "extended care facility." (Section 1861(j).) The use of the unelaborated term "skilled nursing home" in title XIX commits much greater discretion to the Federal administrators. They are not required to use for title XIX the definition of "extended care facility" used in title XVIII, but neither are they precluded from doing so. Insofar as the title XVIII definition describes a skilled nursing home, it affords an appropriate base on which to build the title XIX definition.

Your letter refers to several of the requirements for State plans for medical assistance, including section 1902(a)(9), dealing with standard setting; section 1902(a)(4), dealing with methods of administration; and section 1902(a)(22), dealing with the description of the standards for institutions in which recipients of medical assistance may receive care, and the description of other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality. While these provisions are pertinent to some extent to the questions you raise since they reinforce the Congressional emphasis on the high quality of services under title XIX, they are not directly relevant. They prescribe conditions for the acceptability of the entire plan. They do not govern the definition of "medical assistance" for purposes of Federal matching.

There is considerable overlap among the various provisions. The plan requirement on standard-setting, for example, covers all institutions of the types in which medical assistance may be received; the State authorities set the standards, issue licenses, and take such administrative and judicial action as may be necessary to maintain the standards; if the State does not accept or carry out its responsibilities, the only Federal sanction is to withdraw Federal support entirely from the State plan or the affected part of the State plan. The

meaning of "skilled nursing home", on the other hand, is subject to Federal definition, which is applicable, facility-by-facility, to those homes to which payments are actually made under the plan; if the Federal definition is not met, Federal financial participation is not available in the payments to the particular facility. The Congress has thus provided separate, interrelated spheres for State action and for Federal action, designed to reinforce each other in furtherance of the overall purpose of good care for recipients of medical assistance under the plan.

In summary, we believe that there is ample legal authority for a Federal definition of "skilled nursing home". We also recognize that there are problems regarding the availability of sufficient nursing homes of high quality to serve the needs of potential recipients of medical assistance under title XIX. We shall write soon regarding our program policies on this subject.

Sincerely,

WILBUR J. COHEN,
Under Secretary.

THE UNDER SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., March 1, 1967.

MR. ED WALKER,
*President, American Nursing Home Association,
Miami, Okla.*

DEAR MR. WALKER: At our recent meeting with you and members of your Association, I promised to carefully review our policies with respect to skilled nursing homes under title XIX of the Social Security Act relating to Medicaid. Members of our staff thoroughly reexamined existing policies. I met with a group of State welfare administrators on the subject, and I discussed the matter with Mr. Lloyd Rader, the Director of the Department of Public Welfare for Oklahoma, and Mr. Jearl Smart, President of the Oklahoma Nursing Home Association.

Attached herewith is a revision of our policies based upon the reexamination we have just completed. We believe this revised policy incorporates the best suggestions we have received from various sources; it carries out the Congressional mandate to recognize "skilled nursing care" and it does this with due regard to the practical problems we are faced with today in many places in terms of nursing shortages. The revised policy is now being processed for issuance to replace the policy now contained in H.B. FPAA Suppl. D, D-5130-2.d. and D-5141-4.1.

We should be glad to continue our discussions on any matters of concern at a mutually agreeable time.

Sincerely yours,

WILBUR J. COHEN,
Under Secretary.

REVISED SECTIONS D-5141.4.1 AND D-5130.2.d RELATING TO SKILLED NURSING HOME SERVICES

HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION—SUPPLEMENT D

The definition of a "skilled nursing home" is revised to read as follows: D-5141, item 4.1 A "skilled nursing home" is defined as a facility, or a distinct part of a facility, which meets the following conditions:

(a) The facility is constructed, equipped, maintained, and operated in compliance with all applicable State and local laws and regulations affecting the health and safety of the patients and their protection against the hazards of fire and other disasters, and there is a written, rehearsed disaster plan.

(b) The administrator is qualified by training and experience for successful operation of a nursing home and has the necessary authority and responsibility for management of the facility.

(c) The facility employs staff sufficient in number and qualifications to meet the requirements of the patients accepted for care or remaining in the facility for care.

(d) Food is prepared and served under competent direction, at regular and appropriate times. Professional consultation is available to assure good nutritional standards and that the dietary needs of the patients are met.

(e) Patient care is provided in accordance with written policies formulated with the advice of one or more physicians and one or more registered professional nurses.

(f) Constructive care directed toward restoring and maintaining each patient at his best possible functional level is provided, including activities designed to encourage self-care and independence provided as a part of the patients' treatment program.

(g) Patients in need of skilled nursing care are admitted to the facility only upon recommendation by a physician; the care of such patients is continuously under the supervision of a physician; and the facility maintains arrangements that assure that the services of a physician who can act in case of emergency are continuously available.

(h) The facility provides 24-hour nursing services adequate in quality and amount to meet the needs of the patients who are admitted to, and remain in, the facility. The nursing service is directed by a registered, professional nurse who is employed full time in the facility and is responsible for the total nursing service. At all times, there is a registered professional nurse, or a licensed practical nurse who is a graduate of a State approved school of practical nursing, in charge of the nursing service except that, in those instances in which a licensed practical nurse who is not a graduate of an approved school was successfully discharging the responsibilities of a charge nurse on July 1, 1967, such nurse may be employed in this capacity, only if she has completed training satisfactory to the appropriate State licensing authority.

(i) All drugs and medications are prescribed, handled, stored, and administered in accordance with accepted professional practices.

(j) An individual record is maintained for each patient covering his medical, nursing and related care in accordance with accepted professional standards.

(k) Effective arrangements are maintained through which services required by the patients but not regularly provided within the facility, can be obtained promptly when needed. This includes laboratory, x-ray and other diagnostic services, and regular and emergency dental care. It includes, also, provisions for recognition of need for social services and for prompt reporting of such need to the local welfare department or other appropriate source.

(l) The facility is licensed or formally approved as a nursing home by an officially designated State standard-setting authority.

Any facility that is a participating provider of extended care under title XVIII of the Social Security Act may be assumed, ipso facto, to qualify as a "skilled nursing home".

For an interim period until January 1, 1969, the term medical assistance in section 1905(a) includes services in a facility or a distinct part of a facility which is licensed or formally approved as a nursing home by an officially designated State standard-setting authority and which effective January 1, 1968, has a plan which the State agency determines offers a reasonable expectation that the facility will meet the definition of skilled nursing home not later than January 1, 1969.

Paragraph 2.d. of Section D-5130, *Criteria for the Administration of the Plan*, is revised to read as follows:

(d) Long-term care of patients in medical institutions is provided in accordance with procedures and practices that include the following:

(1) Care is authorized only on recommendation by a physician and after joint consideration by the physician and the social worker of the pertinent medical and social factors, including consideration of alternative arrangements for the patient's care.

(2) There is a medical-social plan for each patient which includes consideration of alternate types of care and which is reassessed periodically.

(3) In making placements, the record is precise as to the medical reason for admission. It shows what alternative methods, such as family care home, social care institution, home health aide, homemaker, etc., have been considered by the admitting physician and the caseworker and specifies the medical-social plan of treatment for the individual.

(4) Each patient is under the care of a physician who has responsibility for continued medical care and planning for that patient, and who visits him at least once a month.

(5) There is a periodic review of the care, treatment and plan for each patient by a physician, nurse and social worker, acting as a team.

(6) In addition to the clinical record maintained by the facility, there is a continuing case record in the agency including the items specified above and (a) regular notes of agency contacts with the patient, with his relatives, with the physician, and with the nursing home; (b) notations regarding the patient's progress; (c) information regarding problems that have arisen related to his care and action taken with respect to them.

(7) Arrangements are made with the State standard-setting authority to certify to the State title XIX agency whether facilities qualify under the definition of skilled nursing home set forth in D-5141.

DAWSON, GRIFFIN, PICKENS & RIDDELL,
Washington, D.C., March 8, 1967.

The Honorable WILBUR COHEN,
Under Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. COHEN: Thank you for your letter of February 25, 1967. At the conference on February 2, 1967 with you and members of your staff, I did state that the Secretary, under well recognized principles of Administrative Law and Canons of Construction, did have limited authority to interpret the term "skilled nursing home care." I said he could interpret that term to require some kind of supporting nursing service. This is as far as he could go in the matter because Congress has specifically limited his authority to fix standards of care. It has said, in no uncertain terms, in Section 1902(a) (9) and (22) that the authority of the states in this matter is not to be disturbed. The House Conferees went so far as to knock out a Senate amendment which gave the Secretary the authority to fix fire and safety standards.

To say that the Secretary can define the term "skilled nursing home service" as requiring some sort of supporting nursing service does not say that he can go beyond this and provide for the qualifications and number of nurses, the medical staff, the physical environment, the dietary requirements, rules governing the dispensation of drugs and so on. When the Secretary does the latter he has gone way beyond interpretation and invades the field of establishing regulations or standards.

A homely analogy would be the term "restaurant" in a statute. The administrator could define restaurant as a place where food was served to the public. Under the guise of interpreting the term "restaurant" he could not provide for the qualifications and number of cooks, the qualifications and number of waitresses, the size and location of the tables, inspections of the kitchen, health examinations for employees and the like.

As you state, Section 1905(a) sets forth 15 types of care and services which are included in the term "Medical Assistance." The fourth one is "skilled nursing home service." The other 14 types are listed and discussed herein below:

Under the guise of construing this term "skilled nursing home services" your department has promulgated and adopted and incorporated by reference all the regulations prepared and promulgated under Title XVIII—all without authority and all without consulting representatives of national organizations involved as was done in formulating these regulations under Title XVIII. Supplement D of these regulations (which you chose to say are not "standards for private and public institutions in which recipients of medical assistance under the plan may receive care or service") are, in fact, regulations which the states are responsible for establishing and maintaining under Section 1902 (a) (9), Supplement D (incorporating by reference the Table XVIII regulations) provides detailed regulations for the following:

I. Compliance with State and Local Laws; II. Governing Body; III. Physical Environment; IV. Medical Staff; V. Nursing Department; VI. Dietary Department; VII. Medical Record Department; VIII. Pharmacy or Drug Room; IX. Laboratories; X. Radiology Department; XI. Medical Library; XII. Complimentary Departments; XIII. OutPatient Department; XIV. Emergency Service or Department; XV. Social Work Department; XVI. Utilization Review Plan.

The 15 types of care which are included in the term of "medical assistance" in Section 1905(a) are:

(1) InPatient hospital services; (2) OutPatient hospital services; (3) Other laboratory and x-ray services; (4) Skilled nursing home services; (5) Physi-

cians' services, whether furnished in the office, the patient's home, a hospital, or a skilled nursing home, or elsewhere; (6) Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law; (7) Home health care services; (8) Private duty nursing services; (9) Clinic services; (10) Dental services; (11) Physical therapy and related services; (12) Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select; (13) Other diagnostic, screening, preventive and rehabilitative services; (14) InPatient hospital services and skilled nursing home services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases; and (15) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary.

By construing these other 14 types of care as you have done in connection with "skilled nursing home service" your department could write regulations setting the standards in each and every segment of the health care field—all, not only without specific authority from Congress, but in fact contrary to Section 1902(a) (9) and (22).

For example, by interpreting the phrase "inpatient hospital service" you could write detailed standards for hospitals in the same 16 fields such as nursing service, medical staff, dietary, etc. By interpreting the words "outpatients hospital services" you could promulgate detailed regulations on all types of outpatient services.

By interpreting the phrase "physician services," "home health care services," "private duty nursing service," "clinic services," "dental services," your department could set nationwide standards in the same 16 or more fields for all of these and other professions' services and completely regulate the health care field all without any authorization from the Congress (and, in fact, contrary to Section 1902).

Your reply of February 25, 1967, on page 2, refers to Section 1905(a) (15) as a source of the Department's authority. That section states that medical assistance means, among other things, "(15) *any other medical care, and any other type of remedial care recognized under State law specified by the Secretary.*"

The term "specified by the Secretary" refers only to "any other medical care and any other type of remedial care recognized by the State" as contained in Subsection 1905(a) (15). It has no reference to "skilled nursing home services" in Subsection 1905(a) (4). Furthermore, the term "specified by the Secretary" does not give the Secretary authority to issue detailed regulations. This phrase merely allows the Secretary to select or to "specify" from two types of care recognized by the States.

In your letter (on page 2) you state that "skilled nursing home service" is one of the five kinds of services that effective July 1, 1967 must be included under State medical assistance plans. You further state that this gives added reason for Federal definition of the term.

As you well know, this term ("skilled nursing home service") has been in the Act since 1960. It seems curious that the Department has administered the Act for 6 years without issuing detailed regulations under the pretext of defining this term. There is little doubt that the Department intends to do this very thing eventually. At the present time, in addition to "skilled nursing home service," it has incorporated the Title XVIII Regulations into only the following definitions:

A. InPatient hospital services; B. OutPatient hospital services; C. Other laboratory and x-ray services; D. Home health care services; E. Institution for tuberculosis; F. Institution for mental disease.

Curiously, "physicians' services" for the time being are defined as those services provided, "within the scope of practice of his profession as defined by state law, by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy." Private duty nursing service, medical care, clinic service, dental service, physical therapy and related services, among others, are similarly defined. With such definitions there could be little quarrel since they are standard recognized definitions. A similar definition for "skilled nursing home service" has existed for several years.

You state that the "unelaborated term skilled nursing home" in Title XIX commits much greater discretion to the Federal Administrators than the detailed definition of extended care facility in Section 1861(j) is not only a complete *non sequitor* but is contrary to the express language of the statute.

Even though Congress laid down 9 conditions in defining an "extended care facility" it provided specifically in Section 1861(j) (10) that an extended care facility also is one which—

"(10) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary * * *"

Contrast this grant of authority to the Secretary under Title XVIII with the language of title XIX in Section 1902(a) (9) given similar authority to the states, as follows; where a state plan must—

"(9) provide for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for private or public institutions in which recipients of medical assistance under the plan may receive care or service * * *"

Your statement on page 6; that whereas Sections 1902(a) (4) (9) and (22) are relevant they do not govern the definition of "medical assistance" for purpose of Federal Matching, is somewhat surprising. Section 1902(a) (9) as quoted above, says that the State authority shall be responsible for *establishing and maintaining standards for private or public institutions* in which recipients of medical assistance under any plan may receive care or services. The Department by promulgating Supplement D "established" standards for private and public nursing homes under the guise it was defining "skilled nursing home services."

Your letter makes no reference to our objections to elimination of supplementation. The Secretary in defining requirements for State Plans under Supplement D (D-5320 and 5330) purports to prohibit supplementation. Since promulgating these regulations, he has given the states until January 1, 1968 to accomplish this.

The Secretary relies on Sections 1902(a) (1) (4) (13) and (19). Not one or all of these subsections give him any such authority.

Let us take 7 states as examples. These are 1966 figures and there may have been some change since then but not very much:

	Rate	Maximum
Alabama.....	\$75	\$250
Arizona.....	125	225
Arkansas.....	175	235
Colorado.....	205	260
Delaware.....	200	200
Florida.....	100	300
Georgia.....	175	250

These are 7 of the 21 states which permit supplementation of some sort. In Florida, for example, where the rate is \$100.00 a month, a nursing home would be unable to take public welfare patients unless the friends or family were allowed to make an additional payment to the nursing home.

Low state payments for nursing homes are certainly not to be encouraged, since it costs more money in the long run. My own state of Virginia used to pay only \$140.00 a month for nursing home care for the indigent. During the 3 years I was on the Alexandria City Council, I recall that because we could not spend more than \$140.00 a month for nursing home care, we had to place countless indigents in hospitals at \$27.50 to \$33.50 a day when nursing home care would have sufficed. There is little doubt but that, in the end, low payments encourage higher costs.

If there is to be a policy against supplementation, then it should be adopted by the Congress. If Congress desires to do away with it, it should be phased out over a 3 to 5 year period. In our several conferences with H.E.W. representatives, we complained about the lack of authority and the severity of phasing it out within one year. It is too severe because nursing homes are expending large sums of money in getting ready for Medicare. Commencing February 1, 1967, nursing homes have been covered under minimum wage for the first time. In many of the southern states this increased unskilled labor costs by at least 25 percent. Other costs have been steadily increasing and many states are having difficulty in getting increased rates to cover only this increase in minimum wages.

South Carolina is a good example. Presently they have state rate of \$175 and allow supplementation to a maximum of \$225.00. The average wage of unskilled help was around 75-cents. On February 1, 1967 it went to \$1.00 with no increase in welfare rates which were there already below the cost of service. The legislature is now struggling to raise these rates from \$175 to \$225 just to take care of the increase in wages. The South Carolina Legislature would have to make a further increase in its monthly rate of \$50 in order to make up for eliminating supplementation. This is too much to expect of a state legislature in one session.

Florida is in such a spot. How can one expect the Florida legislature to raise the \$100 rate to \$300.00 (to make up for the present \$200 allowance in supplementary payments) and at the same time give another raise to take care of the increase brought about by minimum wage and other rising costs. By making Title XIX care the same as Title XVIII care, the Department is already throwing an added burden on the states to match that higher level care and also pay for lesser levels of care for the indigent. Many of the states do not have a regular session this year. The states simply cannot find the money to meet all of these problems in one year.

Moreover, the Department's policy on supplementation is not consistent. They allow supplementation under Title XVIII of the difference between a semi-private room (2 to 4 beds) and a private room. They allow the recipient to pay for such additional services such as television and other similar items.

To summarize, the position put forward in your letter of February 25, 1967 is contrary to the (1) unambiguous language of Section 1902(a)(1) through (22) (2) the explanation of Section 1902 contained in Senate Report 404, Part 1, 89th Congress, 1st session, pages 73-85 and particularly 75-76 (3) the companion House Report No. 213, 89th Congress, 1st session, (4) and the Analysis of the provisions of H.R. 6675 and comparison of then existing laws prepared by the Senate Finance Committee.

I am in receipt of a copy of a letter dated March 3, 1967 from you to President Ed Walker of the American Nursing Home Association in which you enclosed a revision of Supplement D which you propose to promulgate. I believe that the Department is wise in moving backward the effective date of its proposals until January 1, 1969. Likewise, I believe these standards to be somewhat more realistic. However, if the Secretary does not possess the authority to establish standards which was clearly left to the states (which he clearly does not,) it would follow that he does not have the authority to promulgate the standards which you now propose.

Respectfully yours,

JOHN K. PICKENS,

General Counsel, American Nursing Home Association.

The CHAIRMAN. Let's proceed first, Mr. Pickens, to hear the remainder of your witnesses accompanying you and then we will interrogate all of you together.

Who is your next witness?

Mr. PICKENS. Mr. Stephen Morris.

The CHAIRMAN. Mr. Morris. All right.

STATEMENT OF STEPHEN J. MORRIS ON BEHALF OF THE AMERICAN NURSING HOME ASSOCIATION

Mr. MORRIS. Mr. Chairman and members of this singularly important committee. My name is Stephen J. Morris.

The CHAIRMAN. You have almost won your case with that reference.

Mr. MORRIS. I reside in Fresno, Calif. I appear here this morning as a representative of the American Nursing Home Association. My background is the following: I have been the owner and administrator of a nursing home for 30 years and am presently administrator of Wish-I-Ah Lodge, Auberry, Calif., which is a licensed 153 bed facility. I am a former lawyer and an immediate past president of the Cali-

fornia Nursing Home Association. I have been active in associations in this field at the committee and executive level throughout this period of time. I have also been an appointee on several councils for the State of California concerned with the nursing home field. I am a fellow of the American College of Nursing Home Administrators.

The American Nursing Home Association is a nonprofit organization serving the Nation's nursing homes and their patients through educational and research services. It represents in excess of 6,650 nursing homes with more than 300,000 beds in 49 of the 50 States.

It counts among its members both proprietary and nonproprietary institutions. In fact, it has more nonproprietary members than the association which limits its membership to nonproprietary homes for the aged.

It might also interest you to know that proprietary nursing homes carry a higher percentage of welfare patients than do nonproprietary homes.

The association is proud of the role it has played since its inception in 1949 in improving the nursing home picture across the Nation, in raising standards for both facilities and patient care. I might add parenthetically that as late as 1950 only five States had licensing laws regulating nursing homes while today every State has such laws.

Probably no other segment of the health care field has undergone as rapid or as dramatic changes as has the nursing home field in the last decade. Nursing homes, which developed like Topsy for many years, are rapidly moving out of the age of the converted dwelling into an era of modern new facilities specifically designed to provide skilled nursing care in an environment as closely related to that of the traditional family home as is humanly possible.

While the early years of nursing homes were primarily devoted to custodial care and personal services, today nursing homes have come into their own and have joined the mainstream of health care facility development.

Nursing homes, in fact, are playing an ever-increasing role in the health care community across the length and breadth of this land. Not only do they provide skilled nursing care but they also provide the social environment and homelike comforts so necessary to the well being of the geriatric patient. They serve too as convalescent centers—as halfway houses for persons of all ages on the road back from acute hospitalization to their own homes and their own community life.

This is the growing role for the skilled nursing home of today and tomorrow and is the one that is drastically changing the profile of the nursing home.

The association is equally proud of the role it is playing and will continue to assume in the medicare and medicaid programs. More than half the extended care facilities certified under medicare are members of ANHA. It is fair to assume that at least half the beds presently available to patients for nursing home medicare benefits are beds in homes that are members of ANHA.

When you consider that the individual who owns more than one nursing home frequently makes only one of these a member of the ANHA, then, in terms of owners of ECF's, the above percentages would increase substantially.

I have gone over all this to impress upon you that ANHA has a genuine concern for the amendments put forth in H.R. 5710. The association claims for itself no competency in the areas relating to increased benefits and the taxes to pay for them. We do claim, however, a measure of competency in the areas related to health and medical benefits.

We do not wish to appear negative, but, in order to conserve your valuable time, we shall address our remarks to three parts of H.R. 5710 to which we take exception. These are—

1. Section 129, Part 3: Depreciation Allowance for Purpose of Determining Reasonable Cost, as found on pages 57-62 of the bill.

2. Section 131, Part C: Elimination of Requirement of Physician Certification in the Case of Inpatient Hospital Services at the Time the Individual Becomes an Inpatient, as found on pages 71-72 of the bill.

3. Section 205, Title II: Public Welfare Amendments, Disregarding Maximum Expenditures in Determining Amounts of Federal Payments in Certain Cases as found on pages 118-120 of the bill.

In addition to the above, we will address some remarks to the problem of securing sufficient nursing personnel to meet the needs and demands of the Nation's health-care and medical-care programs.

Turning our attention, therefore, to section 129, part 3, let me state at once that the American Nursing Home Association takes exception to including under this section's requirements nursing homes that are of a nongovernmental character and whose coming into existence either was not or is not due to public moneys.

There is universal agreement among accountants that depreciation is an item of operational cost. Further, the record of testimony concerning the reimbursement formula for title XVIII is characterized by almost complete accord that depreciation should be an includable item of cost.

We are, therefore, confronted with a situation wherein the Department of Health, Education, and Welfare is saying in effect that even though an allowance for depreciation is a bona fide cost item, it shall be allowable only if it is mandatorily funded and its expenditure made subject to the decisions of a planning agency.

There then arises the following question: If, as is universally agreed, depreciation is a legitimate reasonable cost item, under what circumstances then can the funding of depreciation be justifiably made mandatory and placed, so to speak, at the community's disposal.

The American Nursing Home Association submits that if it is at all possible to justify the mandatory funding of depreciation, it can be justified only when the item being depreciated was purchased in the first place with community funds in the first instance.

According to a Public Health Service Survey the National Center for Health Statistics, Series 12, \$1, published in June 1963, 87 percent of all nursing homes in the United States are proprietary whose existence was not the result of Federal or other public moneys. Eight percent of America's nursing homes are nonprofit church affiliated

institutions all but a few of which were likewise built with private funds.¹

The remaining 5 percent are community-owned facilities built with public moneys. Therefore, approximately 95 percent of all the nursing homes in the United States were constructed with private capital. Between 1962 and 1966 only 400 nursing homes were constructed with Hill-Burton funds at an average cost of approximately \$13,000 a bed. This is to be contrasted with an average cost of \$7,000 to \$8,000 per bed in nursing homes constructed with private capital.

It is our contention that if not all nursing homes, then at least those whose construction was not owing to public funds should be removed from the requirements of section 129, part 3.

Let me emphasize at this point that the American Nursing Home Association has supported and supports the general principle of the traditional areawide planning that has heretofore existed.

However, let me emphasize even more strongly that the American Nursing Home Association is not prepared to support the radical change in the approach to areawide planning that is embodied in H.R. 5710; namely, that areawide planning be placed in the hands of a "State Agency (designated by the State) which (A) provides for health-care facility and equipment planning in all political subdivisions of the state . . . , (B) coordinate its activities with other agencies engaged in health service planning and participates in (an) interstate and regional health-care facility program . . . (or provides reasonable assurance that it will coordinate)." (P. 60-61, H.R. 5710).

Mr. Chairman and members of this committee, if we read pages 60 and 61 correctly, then where heretofore areawide planning has been voluntary, community staffed and community oriented it now shall become mandatory, implemented from the State capitol and ultimately directed from some regional headquarters embracing several States within its jurisdiction, presumably a Health, Education, and Welfare regional headquarters, since such is the only one presently in existence.

Mr. Chairman and members of this committee, the American Nursing Home Association is not prepared to surrender county and municipal authority, much less a State's autonomy. As representatives of congressional districts which contain counties and municipalities and as representatives of a particular State, we do not believe that you are prepared to do so either.

However, assuming for purposes of clarification that you may be so prepared, ANHA respectfully submits that the factors which make planning desirable do not at this point in time apply to nursing homes in general.

The factors frequently put forth to support planning are summarized and included in the section-by-section analysis of H.R. 5710 as prepared by HEW and I quote therefrom on page 28:

Unnecessary duplication and inefficient use of health care facilities and equipment is wasteful in terms of public monies and scarce health personnel and is a significant factor in the accelerating costs of health care.

¹ Between 1962 and 1966, only 400 nursing homes were constructed with Hill-Burton funds at an average cost of approximately \$13,000 per bed. This is to be contrasted with an average cost of \$7,000 to \$8,000 per bed in nursing homes constructed with private capital.

Again, Secretary Gardner in his statement before this committee on Wednesday morning last stated on page 31 as follows:

None of us wishes to see these Federal funds utilized in competitive drives to put a radioisotope laboratory, a cobalt bomb for cancer treatment, facilities for open-heart surgery, or other costly but highly specialized equipment in every hospital, large or small, regardless of practical requirements.

I would like to point out (1) that the 95 percent of nursing homes referred to above do not compete for Federal funds nor for public moneys; (2) that nursing homes do not utilize, let alone compete, for costly but highly specialized equipment; (3) that the scarce health personnel for whom nursing homes compete are primarily nurses and ancillary personnel.

In respect to these, ANHA submits that the solution to this problem is not to compel funding of depreciation, but rather to embark upon programs which will increase the number of nurses and supporting nursing personnel. I will return to this problem later in my remarks.

Before leaving this provision in H.R. 5710, I would like to add to these remarks quotes from the executive proceedings of the Senate Committee on Finance discussing proposed hospital insurance reimbursement guidelines with officials of the Department of Health, Education, and Welfare, May 25, 1966, as found on page 102 of the committee print and contained within Mr. Ball's commentary on analysis prepared by staff of the Committee on Finance entitled "Proposed Medicare Reimbursement Formula."

The quote is as follows:

Funding is desirable in principle and consideration of enacting of legislation to make it a requirement appears warranted. There are certain issues with regard to compulsory funding that would have to be studied. Proprietary institutions are a special problem since compulsory funding may be considered to have the effect of depriving the proprietor of his own capital—capital may have been invested in a used-up asset and returned in the form of depreciation, but he would be unable to recoup his investment which would be tied up in a fund...

Mr. Chairman and members of this committee, I submit, with all due respect to Mr. Ball, that not because Mr. Ball, himself, says so but because elemental justice requires it that the proprietor of an institution which was not constructed with Federal or other public moneys should not be denied the use of his own funds as would be the case if the proposed amendments to section 129, part 3, as presently found in H.R. 5710 were to be enacted.

I am not at all certain that even when the facility was constructed with public moneys that section 129 should be enacted. A further examination of the record of the hearings of the 89th Congress reveals a continued reluctance on the part of HEW to require funding of depreciation. Let me quote again Mr. Ball from the same source as above:

... Few localities now have effective planning organizations. A requirement that there be effective planning before funds could be spent might tie up the depreciation—funds of much of the hospital system until a network of acceptable planning agencies is brought into existence. It should also be noted that a requirement of funding does not mean depreciation funds will constitute the major source of capital; in Cleveland, one of the few areas where such a requirement has existed for many years, over a 10-year period capital expenditures were 4.3 times total funded depreciation.

The inclusion by HEW of mandatory funding in the present H.R. 5710 represents a significant change in the thinking of HEW from what it was in May 1966, less than 10 months ago—and even less than that if one were to assume that H.R. 5710 was months in preparation.

Mr. Chairman and members of the committee, objectivity has always required that when one puts forth a proposal embodying a change in the status quo, that he submit along with such proposal the need for the proposed change and the factors which have caused the change in his thinking.

Is it improper for us to inquire whether there now exist many localities that have effective planning organizations when only 10 months ago few such localities existed?

Is it improper for us to inquire whether there now exists a network of acceptable planning agencies when only 10 months ago no such network existed; whether, therefore, there no longer exists the danger that the depreciation funds of much of the hospital system might be tied up because of the lack of such a network when only 10 months ago such a danger clearly existed?

Is it improper for us to inquire whether the prolonged experience of Cleveland which demonstrated that funded depreciation was not a deterrent to capital expenditure is no longer demonstrable and significant when only 10 months ago it was singularly so?

In short, is it improper for us to inquire if section 129 does not indeed represent a reach for excessive authority on the part of Health, Education, and Welfare that is at least premature if not entirely unwarranted?

In summary, then, the American Nursing Home Association takes exception to including nursing homes that are of a nongovernmental character and whose coming into existence was not nor is not owed to public moneys under the requirements of section 129 because:

- (1) Such a requirement would have the effect of depriving the proprietor of his own capital;
- (2) Nursing homes do not now utilize and therefore do not compete for costly but highly specialized equipment; and
- (3) The solution to the problem of scarce health personnel, namely, nurses, for which nursing homes do compete is in no way related to the mandatory funding of depreciation.

Turning now to the second of the three items in H.R. 5710 to which the American Nursing Home Association takes exception; namely, section 131 as found on page 71, let me hasten to say that here we do not wish anything to be deleted but rather that something be added, specifically that the elimination of the requirement of physician certification in the case of inpatient hospital services at the time the individual becomes an inpatient be broadened to include nursing homes as well as hospitals.

The heart of the matter here is that the fact that a physician has a patient admitted to the hospital is sufficient evidence of the patient's need for hospital services and that this is fully understood within the medical, hospital, and private health insurance communities, and moreover, backed up by the provision for utilization review.

In short, that the physician's professional competence and integrity stand behind his having had the patient so admitted.

We subscribe to this argument and submit that this is no less true of the physician's admitting a patient to a nursing home than it is of the physician's admitting a patient to a hospital.

In each instance, what is at work is the physician's professional competence and integrity and in no wise involves that of the health care and/or medical care facility.

To argue otherwise is to say that the physician's professional competence and integrity are schizoid; that the physician is a Dr. Jekyll in relation to hospitals and a Mr. Hyde in relation to nursing homes.

In short, it is to argue that the physician has truly neither professional competence nor professional integrity. We do not concur in such an argument. To the contrary, we commend and stand beholden to the competence and integrity of the Nation's medical profession.

In summary, then, ANHA asks that section 131, as found on page 71 of the bill, be broadened to include admission to a nursing home as well as to a hospital.

Turning now to the third and last of the items within H.R. 5710 to which the American Nursing Home Association takes exception; namely, section 205, here, again we take exception not because of what is contained therein but because of what is lacking therein.

However, Mr. Chairman, it appears that our association is placed in a rather precarious position in our statements of support for section 205—that is to say, we are almost damned if we do and damned if we don't. If section 205 is intended to give States, if they so elect, Federal matching funds, based on title XIX formulas, for titles I, X, XIV, and XVI recipients who are cared for in nursing homes—in other words, allow a continuation of the much-needed and necessary long-term nursing home care, regardless of whether we are willing to admit this could or should be done under title XIX or the public assistance titles—then of course we would support this intention.

However, if the intention of section 205 is to allow the Department of Health, Education, and Welfare broad new powers to determine various and as yet nondefined "living accommodations" to be utilized instead of nursing homes, then we would have to be opposed.

We feel that the problem intended to be alleviated by section 205, and hence the need for section 205 itself, could both be voided if the Secretary would return the authority to the States to determine their own standards and needs based on their resources and abilities.

In any event, it is our present belief that section 205 is far too ambiguous and should be amended to more clearly state its objectives. Towards this end we would like to suggest that the following language be substituted in place of the present highly ambiguous wording.

Section 1119, beginning on page 119, line 19—

but only in the case of those recipients with respect to whom there is a timely physician's certification of need of special living arrangements in a medical care facility licensed by the appropriate State agency and that if such arrangements are not furnished to such recipients in appropriate institutions or their own homes under a program of a licensed home health agency, such recipients will require care in nursing homes.

The amendment as put forth would require that payments for such patients, even though made according to the formula for title XIX payments, would be money payments rather than vendor payments as in title XIX, itself.

As you know, there is an essential difference between money payments and vendor payments. The former are payments made directly to the individual, in this case, the patient, while vendor payments are made to the institution. This seemingly innocent difference contains within it the seeds of many and sometimes heart-rending difficulties to the patient, to the institution, and to the Government agency.

The overriding principle should be that if the purpose for which the money was allocated be realized; that if the Government has allocated these sums to pay for health care and/or medical care that these moneys be so utilized. There exists two potential roadblocks within the money payment system that can frustrate this principle. These may be categorized as medical and social.

The first of these, the medical, derives from the inability of the patient to endorse or even to recognize the check he has received. Frequently, the patient is unable to understand that he has an obligation to pay. The source of these disabilities are often due to a variety of medical infirmities.

The second of these, the social, is even more tragic and reprehensible. It derives from someone, usually a member of the patient's family or someone else armed with the power of attorney, who will intercept the patient's check, convert it and employ the money for his own personal use.

Finally, to employ a money payment system is to take a step backward. Presently, there are 38 States which have vendor payments. This was the result of a long and arduous struggle on part of the American Nursing Home Association and others. To now force these States to return to money payments would not only be to retrogress but would, in fact, represent an aborted opportunity to place all States on a vendor payment basis.

In summary then, ANHA endorses the provisions of section 205 but requests that the committee add language which would insure that the basis for payments under this program be that of vendor payments notwithstanding anything to the contrary in existing law.

I would like now to address some remarks to the problem of the increasing shortage of nursing personnel to staff the Nation's hospitals, sanitoriums, physicians' offices, research laboratories, home health agencies, and nursing homes.

The shortage of registered nurses, licensed practical nurses, and nurses' aids is particularly acute in the nursing home field because, we are frank to admit, care of the aged, chronically ill and, in many cases, the senile, ranks at the bottom of the medical profession's glamor jobs.

One facet of this problem was revealed in a Public Health Service study by the National Center for Health Statistics, series 12, No. 6, conducted in 1964 which showed that the median age of RN's and LPN's in nursing homes was 48. In other words, half of the registered nurses and licensed practical nurses were 48 years of age or older. This survey was dramatic evidence of the fact that young people are not, and have not, been entering into the nursing home field.

The demand for nursing personnel of all types, RN's, LPN's and NA's, will continue to rise due to increased staffing requirements on the part of nursing homes qualifying under the medicare and medic-aid programs, the increasing utilization of hospitals and nursing

homes, and the rapid expansion of nursing homes to meet the needs created by the titles XVIII and XIX programs.

The nursing personnel shortage is, and rightly so, a matter of great concern to this committee, since in the final analysis the ability of health care institutions to provide the services pledged under these two programs depends upon their ability to recruit trained personnel.

Thus it behooves this committee to be concerned with programs, both in and out of Government, which discourage young people from enrolling in hospital schools of nursing and licensed practical nursing schools.

Incredible as it may seem, some educators and at least one major professional organization are trying to eliminate completely the program of training licensed practical nurses at a time when the need for bedside nursing is far outstripping the supply of competent personnel.

Further, it is imperative that this committee be aware that there are those in high Government posts who would use the new titles XVIII and XIX programs to abolish the licensed practical nurse staffing system which has proved equally effective in hospitals, sanatoriums, and nursing homes in years past—and, by this device, eliminate from participation in either the medicare or medicaid programs a large number of sorely needed nursing home beds.

We disagree emphatically with those who would eliminate as charge nurses any practical nurse who is not a graduate of a State-approved school. It has been our experience in the nursing home field that many of our best employees, those with the greatest empathy for the aged patient and with the most experience in their care, are not graduates of State-approved schools primarily because their age and experience predates the major development of these schools.

Possibly as many as half the licensed practical nurses in this country are nongraduates. Many of them were students in hospital schools of nursing who, for one reason or another, were unable to complete their formal education.

These, and many others, have however, taken hundreds of hours of extension courses in their field and most importantly, have passed State licensing examinations, just as have graduates of State-approved schools.

It is this requirement for charge nurses that has kept many otherwise fine nursing homes from seeking to become certified as ECF's for care of medicare beneficiaries.

The illegal, and wholly unjustified, attempt by HEW officials to require all homes caring for title XIX patients to meet these same standards of staffing would eliminate thousands of homes from this program.

Literally tens of thousands of your constituents, now receiving excellent care in these same homes under existing Federal-State programs, will thus be deprived of the care to which they are entitled, or will have to be resettled in other facilities, perhaps hundreds of miles from their home communities and relatives.

In concluding my remarks on the nursing personnel shortage, I suggest that this committee should exert its influence to create massive training programs to produce more registered nurses, licensed practical nurses, and nurses aids, and to help establish special inservice training programs for those already in these fields.

The urgency of this situation cannot be overstated, for available information clearly indicates that by 1975—a scant 8 years from now—the number of nursing home beds will more than double, creating a demand for these skills far beyond that which can reasonably be met under existing programs; as indeed it is doubtful it can be met at present.

Mr. Chairman and members of this committee, I wish to thank you personally and on behalf of the 6,650 members of the American Nursing Home Association for affording to us the opportunity to appear and be heard before you this morning. We will attempt to answer any questions which you might want to put to us.

Thank you once more.

The CHAIRMAN. Thank you, Mr. Morris, and without objection the supplementary and summary statement appended to your main statement will be included in the record at this point.

(The information referred to follows:)

PROFILE: NURSING HOMES, 1967

(Prepared by the American Nursing Home Association, Washington, D.C.; for the Committee on Ways and Means, House of Representatives)

INTRODUCTION

It is no secret to the Members of this Committee that nursing homes have emerged from the shadows of the health care field during the past decade. The sordid, shameful fact is that society, for too many years, had turned its back on the aging and the elderly in its midst. Where once, in centuries past, the aged and infirm were revered and honored, they suddenly had become a burden and a liability.

There are many in the nursing home field today who assumed this burden and this liability many years ago and who, over the years, have raised anguished voices in behalf of those in their care.

Nursing home leaders have fought for community, state and federal recognition of the problems of our patients. We have fought for improved standards and licensing of facilities caring for the elderly. We have fought for increased state and federal appropriations to enable us to provide better care. We have created an organization, the American Nursing Home Association, to provide a sounding board for our policies and programs designed to improve the level of care in nursing homes and to win recognition for our *informed* views at the council tables with other medical and paramedical professions.

The dramatic changes which have occurred in the nursing home field in recent years in part can be traced to our efforts, but even more so to the work of an enlightened Congress which adopted and continually improved the Kerr-Mills Medical Assistance to the Aged program and its successor legislation, Titles XVIII and XIX as developed in the Social Security Amendments of 1965.

To the disinterested observer it might appear conclusively, that all the battles have been won, the victory sealed and that we, in the nursing home profession, might now devote our full energy and resources to the prime mission—providing the best care possible to the Nation's aging and elderly citizens. There is a tendency on the part of some in the high echelons of government to say: "We have provided the program and the regulations . . . now go about your work and get your job done."

The truth is that the fine work done by this Committee, and its predecessor committees on both sides of Congress, in shaping the Title XVIII Medicare program and the Title XIX medical assistance program is in danger of falling down about our ears like a house of cards—partly because the INFORMED views of those of us who have been on the firing line in the nursing home field for many years are being ignored by administrative agencies—and partly because those responsible for administering these two fine programs refuse to face the realities of life in our free enterprise system.

This "Profile: Nursing Homes, 1967," has been prepared to put in proper perspective the nursing home field, its progress, its weaknesses, its problems. It

is designed to tell you something about this field, the facilities, the patients, the personnel. We trust that it will help explain to you our positions on legislation you are considering which will dramatically influence the future of the nursing home profession whose potential in the total health care picture of the Nation has barely been tapped.

AMERICAN NURSING HOME ASSOCIATION

In its 18th year, the Association has a membership of some 6,650 nursing home facilities representing nearly 300,000 patient beds. It is a non-profit organization which provides educational, informational, research and legislative services to its member homes which include both proprietary and non-proprietary facilities in 49 of the 50 states and Canada. Its offices are located at 1101 Seventeenth Street, N.W., Washington, D.C. 20036.

NURSING HOMES

Licensed nursing homes in this country numbered 13,685 with a bed capacity of 576,586, according to state licensing agencies surveyed by ANHA as of January 1, 1966. In addition, the Public Health Service reported that in mid-1965, there were an additional 6,000 related facilities providing personal care with or without some nursing services with a bed capacity of about 235,000.

Of the nursing home bed capacity, the ANHA Survey indicated some 300,000 had been built between mid-1961 and mid-1965. An estimated 60,000 beds were opened in new facilities in 1965 and another 70,000 were reported scheduled for opening in 1966. Just what effect the tight money market and the confusion over Medicare reimbursement has had on construction the last few months has not been determined.

The 300,000 new beds added during the five year period represented a capital expenditure conservatively estimated at \$1.5 billion with most coming from the private sector of the economy. During the same period, Federal Hill-Burton funds totaled \$102.3 million of the \$291.9 million spent to provide only 22,699 beds in 400 Hill-Burton non-profit homes.

This tremendous building boom not only has reflected the changing nursing home picture but has influenced the change.

Whereas in 1954, the average size nursing home was 25 beds, by 1961 it had become 31 and in 1966 it was 42. New homes built in 1965 averaged 58.1 beds and those reported under construction in 1966 were 65.3 beds on the average.

With the increased size has come improved overall professional staffing, improved services in the fields of rehabilitation, restoration, recreation and occupational therapy, as well as improved nursing care.

The Public Health Service reports that 87 per cent of the nursing homes in the country and about three-fourths of the beds are privately owned. Five per cent are church owned, three per cent owned by other non-profit organizations and 5 per cent by government.

PATIENTS

Eighty-eight per cent of the patients in nursing and personal care homes (according to a 1963 PHS study) are 65 and over, and 70 per cent are 75 and over. The average age is 77.6. Women patients outnumber men by almost two to one.

But age is not the full story.

A major 1963 survey by the PHS of those in nursing homes and related facilities showed that 48 percent could not walk without assistance and one in four was unable to walk at all. Half of them were confused all or most of the time, 19 percent were totally incontinent and 17 percent were usually bed ridden.

About one-third of the patients studied by PHS in 1963 had been in the home less than one year. The average length of stay was 2.5 years in nursing care homes and three years when both nursing care and related facilities were considered together. The average length of stay was shorter in proprietary facilities than in non-profit or governmental facilities.

PERSONNEL

The Public Health Service survey of 1964 showed that some 299,000 persons were employed in nursing homes and related facilities, and that of this number, 281,000 worked 15 or more hours a week.

More than half were nursing personnel including 17,400 registered nurses, 20,500 licensed practical nurses and 113,800 nurse's aides. About one-third of 20,700 administrators also were reported to be either registered nurses or licensed practical nurses.

Nine out of 10 of the employees were women and half were 48 years or older. In nursing care homes the ratio of patients to RNs was 26 to 1; the ratio of LPNs was 21 to 1 and there was one aide for every four patients. The nursing and professional staff accounted for 66.2 percent of the employees in nursing care homes.

While there was little difference between the ratio of residents to RNs between proprietary (32), non-profit (40) and government (34), the significance was more pronounced with LPNs where the ratios were 22 for proprietary, 37 and 38 for non-profit and government respectively, and 4, 8 and 5 in that order for aides.

The shortage of nursing personnel is a major problem for nursing homes as it is for other health care facilities. It is estimated that the annual turnover rate for nurses in the health industry is 60 percent; 70 percent for nurse's aides and more than 33 percent for licensed practical nurses. Nevertheless, a PHS survey of 1964 showed that nursing homes had RNs with a median of 10.6 years experience and LPNs with a median of 8 years experience.

PUBLIC ASSISTANCE

Between 50 and 60 percent of the patients in nursing homes received some form of public assistance. Nearly a half billion dollars is spent providing nursing home care for the needy and the medically indigent. Under vendor payments alone in 38 states, \$133,564,000 was spent in fiscal 1965 to care for 169,000 persons. During the same year, \$266,784,000 was spent for the care of 173,000 patients under MAA programs in 31 states with the bulk being in California (36,300), Massachusetts (24,300), and New York (28,300). An additional \$2.8 million was spent under the aid to the blind program and for 2,600 patients and \$42.6 million for the care of 33,400 under the Aid to the Permanently and Totally Disabled.

A 1964 PHS study showed that proprietary nursing care homes had 54 percent of their patients on public assistance. Voluntary homes had 40.4 percent and Government-owned homes 61.5 percent.

Welfare rates, on the whole are totally inadequate to insure quality care. One-half the states, according to a January 1, 1966 survey of state agencies by the American Nursing Home Association, paid an average of less than \$5 a day for nursing home care. Three states paid less than \$100 a month for *maximum care*. One-half of the states were paying less than \$7 a day for maximum care and only six states were paying \$10 a day or more. (According to an unpublished report circulated during discussions of the Title XIX regulations in 1966, estimates of nursing home costs under Medicare were running from \$15 to \$25 a day).

These welfare rates affect the overall quality of care in nursing homes across the country. Many excellent homes do not care for any welfare patients. In other quality homes that do accept welfare patients, private paying patients have been subsidizing their care. Eighteen states have allowed supplementation by relatives or other community agencies to make up for inadequate welfare rates.

It is obvious that inadequate welfare rates have played a major role in holding down adequate staffing patterns of nursing homes and related facilities in many areas.

In some states, public officials reportedly have overlooked failures of some homes (particularly those carrying heavy welfare patient loads) to meet all state licensing standards. In other states, where no vendor payments are allowed and the aged on public assistance must purchase their care through their welfare checks, "bootleg" unlicensed homes have flourished. The ANHA and its member state associations have sought to obtain payments that would bring about improved standards and enforcement of these standards in all areas.

MEDICARE

As of February 23, 1967, the Social Security Administration reported that 3,374 facilities had been certified as Extended Care Facilities to provide for care of Medicare beneficiaries.

Skilled nursing homes accounted for 2,597, or 77 per cent of these facilities. Extended care units in hospitals accounted for 14.5 per cent or 488; and there were 289 units certified in other health care facilities.

Skilled nursing homes produced 81 per cent or 199,404 of the 245,650 beds certified. Hospital units represented 27,054, or 11 per cent and other facilities, 19,192 or 8 per cent.

Many good nursing homes have not qualified for the Medicare program by their own choice, primarily because of the inadequacy of the Medicare reimbursement formula which provides for reimbursement of allowable costs (and many costs are not allowed) plus 1.5 percent for immeasurable costs and about 7.5 per cent on the owner's equity.

This formula will not produce the return that makes investment in a nursing home attractive for private capital. The formula also makes it difficult for both private facilities and non-profit facilities built without public funds to meet their mortgage payments and to put aside funds for improvement of their equipment and programs.

The proposal to require funding of allowances for depreciation will worsen the situation and drive more homes out of the Medicare program. The proposal to make every facility, whether publicly or privately financed, subservient to area health planning council ideas on construction and improvement of nursing homes if they are allowed depreciation as a cost factor in either Title XIX or Title XVIII would mean the ultimate death of the free-standing nursing home and will return the country to a 1970 version of the despicable county poor farm or almshouse of the early 20th and late 19th centuries.

Recently a study of patients who had been admitted to a nursing home from a hospital (under conditions similar to Medicare) was made by ANHA in cooperation with Mutual of Omaha. The study covered 3,793 cases in 160 nursing homes.

One conclusion: The average patients will have to stay in a nursing home longer than the maximum 100 days provided for in the Medicare program.

Broken down into seven major groups, the study produced these results: Stroke patients accounted for 30.5 percent of the cases with an average stay of 127.7 days; Heart disease accounted for 27.9 percent with an average stay of 117.1 days; fractures, 14.9 percent and an average stay of 133.6 days; cancer, 11.7 percent and an average stay of 83.2 days; mental, 5.9 percent with an average stay of 136.8 days; diabetes, 5.5 percent with an average stay of 127.4 days; and arthritis, 3.6 percent and 167.1 days average stay.

While seven out of 10 cancer patients died in the home, the death rate was high for the study with 45.9 percent dying in the home.

For the one-third who used the nursing homes as a "halfway house" between acute hospitalization and return to their own residences, the average stay was 78.5 days. The range for this group was 100.7 days for cancer patients to a low of 60.9 days for diabetes patients. Half the patients were over 75 but no definite link was found between age and length of stay.

The study also would indicate that the requirement for utilization review at the end of 14 days and again 30 days later may be too stringent and an unnecessary cost since the shortest average length of stay was 61 days for diabetes patients and 62 days for heart patients.

GENERAL CONCLUSIONS

Nursing homes, through expansion of programs for restoration and rehabilitation, offer an opportunity for the Nation to hold down institutional health care costs by providing a facility for greater use of convalescence after hospitalization.

Private capital has been and is available for financing of nursing homes and has succeeded in eliminating many of the obsolete and unsafe converted structures that marked the beginnings of the nursing home institution. More than half of the beds now in existence have been built since 1961 and there was also a great deal of construction in the late 1950s. Today's nursing homes are designed specifically for care of the aged, the chronically ill and the convalescent and their programs have developed to implement these designs.

With increased standards and increased staffing requirements must come increased payments for care. As long as there is a dependency on state funds, the wishes of the states and their elected officials, who must appropriate funds for patient care, will in a large degree control the quality of care.

SUMMARY OF STATEMENT OF STEPHEN J. MORRIS, AMERICAN NURSING HOME ASSOCIATION

The American Nursing Home Association takes exception to the following in H.R. 5710:

(1) Section 129, part 3, Depreciation Allowance for Purpose of Determining Reasonable Cost, p.p. 57-62 of the Bill.

(2) Section 131, Part C, Elimination of Requirement of Physician Certification in the Case of In-Patient Hospital Services at Time Individual Becomes an In-Patient, p.p. 71-72 of the Bill.

(3) Section 205, Title II, Public Welfare Amendments, Disregarding Maximum Expenditures in Determining Amounts of Federal Payments In Certain Cases, p.p. 118-120 of the Bill.

In addition to the above, certain remarks in relation to the shortage of nursing personnel.

Position: The American Nursing Home Association takes exception to including nursing homes that are of a non-governmental character and whose coming into existence was not nor is not owed to public monies under the requirements of Section 129.

Reasons:

(1) Such a requirement would have the effect of depriving the proprietor of his own capital.

(2) Nursing Homes do not now utilize and therefore do not compete for costly but highly specialized equipment.

(3) The solution to the problem of scarce health personnel, primarily nurses, for which nursing homes do compete is not to be found in the mandatory funding of depreciation.

Position: The American Nursing Home Association objects to mandatory area-wide planning made subject to a State Agency and oriented towards the needs of a region embracing several states as envisioned in Section 129, pp 60-61 of the Bill.

Reasons:

(1) This is a departure from areawide planning as presently exists, namely, planning that is voluntary, community-staffed and community-oriented.

(2) This concept of planning does away with the autonomy of a State and renders the State *subordinate* to the region.

(3) This concept of planning will eventually and rapidly lead to control of planning by the Regional HEW headquarters.

Position: The American Nursing Home Association asks that Section 131, as found on page 71 of the Bill, be broadened to include admission to a nursing home as well as to a hospital.

Reason: Whether a patient be admitted to a hospital or to a nursing home, in each instance what is at work is the physician's professional competence and integrity and in no manner involves that of the health-care and/or medical care facility.

The fact that a physician has a patient admitted to a facility is sufficient evidence of the patient's need for the services of that facility.

Position: The American Nursing Home Association endorses the provisions of Section 205 but requests that the Committee add language which would insure that the basis for payments under this program be that of vendor payments notwithstanding anything to the contrary in existing law.

Reasons:

(1) The overriding principle is that the purpose be realized for which money has been allocated; that if the government has allocated sums to pay for health-care and/or medical care that these monies be so utilized.

There exists two potential road-blocks within the money payment system that can frustrate the above principle. These may be categorized as medical and social:

Medical: The frequent inability of the patient to endorse or even to recognize the check he has received. Frequently the patient is unable to understand that he has an obligation to pay. The source of these disabilities are often a variety of medical infirmities.

Social: Someone—usually a member of the patient's family or someone else armed with the power of attorney—who will intercept the patient's check, convert it and employ the money for his own personal use.

(2) To employ a money payment system is to take a step backwards. Presently, there are 38 states which have vendor payments. This was the result of a long and arduous struggle on part of ANHA and others. To now force these States to return to money payments would not only be to retrogress but would, in fact, represent an aborted opportunity to place all States on a vendor payment basis.

The CHAIRMAN. Mr. Pickens.

Mr. PICKENS. Mr. Chairman, Mr. Marvin Smith is here and his statement has been distributed. If you feel in the interest of time you would rather have him give his statement prior to questions, fine, whatever your pleasure.

The CHAIRMAN. Mr. Pickens, we have been an hour and 15 minutes. How many more do you have on behalf of the American Nursing Home Association to testify?

Mr. PICKENS. We have one witness that hasn't arrived yet. Mr. Marvin Smith's statement is only about four pages.

The CHAIRMAN. Why don't we proceed in the order you want to, but let's do it as rapidly as we can, if you will, gentlemen.

Mr. PICKENS. All right. Mr. Marvin Smith.

The CHAIRMAN. If you omit parts of your statement, do so with the knowledge that the full statement will be included in the record. Be sure you give us your pertinent points so we will know what they are.

STATEMENT OF MARVIN SMITH ON BEHALF OF THE AMERICAN NURSING HOME ASSOCIATION

Mr. SMITH. Mr. Chairman, I am Marvin Smith, a certified public accountant from Denver, Colo. I appear here today in behalf of the American Nursing Home Association in my capacity as a member of the professional consultation staff of the American Nursing Home Association.

For the period July 1, 1964, to June 30, 1965, I was a member of the consultation staff of the Department of Health, Education, and Welfare in the nursing home branch. For a short period prior to that time, I aided the Department of Health, Education, and Welfare on accounting problems which the nursing home area of the Department was at that time emphasizing.

I am here today to testify concerning an important accounting aspect in connection with the present reimbursement formula and the proposed original Miller amendment, and in the proposed H.R. 5710 which deals with funding of depreciation.

Under the present law, funding of depreciation is not required, and if funding is voluntary, the interest income thereon is not a reduction of allowable expense.

However, the potential interest income on the funded moneys will not justify the restriction on working capital of the facility and will necessitate increased borrowing to compensate for working capital shortage.

If we presume the facility is unable to acquire additional funds for working capital purpose, the facility will be compelled to lower expenses by restricting services to a minimum. This will lead to one of two courses: (1) Going out of business or being forced out through

something similar to bankruptcy, or (2) lowering standards to a point of not being qualified to participate in the program.

Let us presume, on the other hand, that the facility is able to acquire, through borrowing, additional funds for working capital. The interest paid on these borrowings will be an allowable cost, subject to reimbursement. We, therefore, have on one side the restricted funds earning interest which is not a reduction of allowable costs, and on the other side we have necessary borrowings and the interest cost thereon is an allowable cost. This defeats the objective of maintaining "reasonable costs" at a minimum.

We must not overlook an important facet of proprietary nursing homes. Admittedly, depreciation is a noncash expenditure and is reimbursable cost under the medicare program. The mortgage payments, or other long-term obligation payments, are not considered costs; rather these are a reduction of liabilities and the funds to make these payments must come from noncash expenditures and from profits. Very seldom will profits alone be adequate to pay for long-term indebtedness and to pay for income taxes on the profits.

Funded depreciation requires the operating entity to be one whose life is not limited by its owner's life expectancy. A change of ownership would require the new owner to have enough cash to purchase the facility and its cash depreciation fund. Where new investors must also purchase a large amount of cash in the depreciation fund, this alone will discourage the potential investment.

Investors will play an important part in the program if services are to be provided to all who require extended care. Additional restrictions on moneys generated by an extended care facility will discourage anyone contemplating the acquisition of or construction of such a facility.

I would like to discuss the present reimbursement formula. There apparently has been much said about the 7½-percent factor on net equity. I firmly believe that unless a careful study of the meaning of this formula is made, many are led to believe that the facility is guaranteed a fair return on the investment.

Actually, this percentage is prorated by the number of medicare patients.

In other words, if the facility has 20-percent medicare patients the rate of return is 20 percent of 7½ percent or 1½ percent of net equity. I would like to recommend that a more realistic formula be devised to compensate those facilities who, because of various financial circumstances such as leased facilities or high debt ratio and low net equity, are more adequately compensated for the risk factor inherent in this type of business.

As regard the reimbursement portion of 1½ percent over cost, this, too, is an area in need of a more realistic formula. It is important that we are cognizant that this percentage also is prorated to the number of medicare patients. This could bring the percentage figure to almost a negligible amount. With all the potential areas of cost which could be argumentative as to whether they are or are not "allowable costs" there is a minimal amount of difference between a break-even point and a loss.

Attached to and made a part of this report is a schedule showing reimbursements under the original HEW formula and the substitute

Miller bill which was adopted by the Senate and House. Under the present Miller bill a facility with a \$320,000 investment and 20 percent medicare patients will make an annual profit based on net equity of \$1,322 or \$110 per month.

Under the original Miller bill the same facility with 20 percent medicare patients would have earned \$4,800 or \$400 per month. The original Miller bill should be considered as a more equitable approach to a reimbursement formula as it embodies different types of facilities, that is to say, leased properties as related to owned properties and places all in the same unbiased category.

Thank you.

The CHAIRMAN. Mr. Smith, the material appended to your statement will also be made a part of the record at this point, without objection.

(The information referred to follows:)

Comparison of: I. *Original HEW Formula*; with II. *Substitute Formula*; with III. *Original Miller Bill*.

ANY NURSING HOME

Schedule of allowance in lieu of unrecognizable costs based upon allowable cost factors

	Nursing home A	Nursing home B	Nursing home C	Nursing home D
Total cost of services performed.....	\$150,000	\$90,000	\$350,000	\$350,000
Interest included in costs.....	9,000	2,000	24,000	30,000
Allowable costs.....	141,000	88,000	326,000	320,000

I. *Present formulas—(2 percent allowance limited by 4¼ percent interest (whichever is lesser) under principle 1-11)*

	Nursing home A	Nursing home B	Nursing home C	Nursing home D
A 4¼-percent interest factor on net investment in plant property (i.e. land, building, and equipment, line 5 less the combination of lines 7 and 11) equals.....	\$2,375.00	\$665.00	\$9,500	\$4,750.00
If the nursing home has medicare patients of:				
15 percent—Its reimbursement would be....	356.25	99.75	978	712.50
20 percent—Its reimbursement would be....	475.00	133.00	¹ 1,304	950.00
25 percent—Its reimbursement would be....	593.75	166.25	¹ 1,630	1,187.50
30 percent—Its reimbursement would be....	712.50	199.50	¹ 1,956	1,425.00

¹ The 4¼ percent interest factor in this one instance is limited by the 2 percent allowance since the interest is more.

II. *Substitute Miller bill as adopted by Senate and House*

	Nursing home A	Nursing home B	Nursing home C	Nursing home D
1. 7½ percent net equity (including working capital, etc.).....	\$4,500	\$1,500	\$17,250	\$9,750
2. 1½ percent costs.....	2,115	1,320	4,890	4,800
Total.....	6,615	2,820	22,140	14,550
If the nursing home has medicare patients of—				
15 percent, its reimbursement would be....	992	378	3,321	2,183
20 percent, its reimbursement would be....	1,322	564	4,428	2,910
25 percent, its reimbursement would be....	1,653	660	5,535	3,638
30 percent, its reimbursement would be....	1,983	846	6,642	4,365

III. Original Miller bill

	Nursing home A	Nursing home B	Nursing home C	Nursing home D
7½ percent fair market value ¹	\$320,000	\$140,000	\$860,000	\$860,000
If the nursing home has medicare patients of—				
15 percent, its reimbursement would be.....	3,600	1,500	9,675	9,675
20 percent, its reimbursement would be.....	4,800	2,000	12,900	12,900
25 percent, its reimbursement would be.....	6,000	2,500	16,125	16,125
30 percent, its reimbursement would be.....	7,200	3,000	19,350	19,350

¹ Using total assets at cost as fair market value.

Table below used in computing percentage allowance on invested capital and percentage allowance on net investment in plant property

	Nursing home A	Nursing home B	Nursing home C	Nursing home D
ASSETS				
Cash.....	\$10,000	\$3,000	\$35,000	\$35,000
Receivable (collectible).....	8,000	6,000	18,000	18,000
Other assets (i.e., utility deposits, prepaid expenses, etc.).....	2,000	1,000	7,000	7,000
Cost of land, building, and equipment.....	300,000	130,000	800,000	800,000
Total assets at cost.....	320,000	140,000	860,000	860,000
Less depreciation on building and equipment.....	100,000	80,000	200,000	200,000
Net assets at book value.....	220,000	60,000	660,000	660,000
LIABILITIES				
Accounts payable and other current liabilities (i.e., payroll taxes, accrued wages, etc.).....	10,000	4,000	30,000	30,000
Mortgage payable.....	150,000	36,000	400,000	500,000
Total liabilities.....	160,000	40,000	430,000	530,000
Net invested capital.....	60,000	20,000	230,000	130,000

Mr. SMITH. Thank you.

The CHAIRMAN. Mr. Pickens.

Mr. PICKENS. Mr. Wick has just arrived from Florida, but I think he needs a minute to catch his breath, so if you would like to proceed with the questioning then he would be available.

The CHAIRMAN. Mr. Wick is your last witness?

Mr. PICKENS. He says he is ready.

The CHAIRMAN. All right. Come forward, Mr. Wick. Let's hear from you then.

Mr. Wick, please identify yourself for our record by giving us your name, address, and capacity in which you appear.

STATEMENT OF CHARLES Z. WICK, AMERICAN NURSING HOME ASSOCIATION

Mr. WICK. My name is Charles Z. Wick. I am president of United Convalescent Hospitals, Inc., 9107 Wilshire Boulevard, Beverly Hills, Calif. I am appearing here as a member of the nursing home industry.

The CHAIRMAN. Mr. Wick, if you desire to omit any part of your statement, do so with the full knowledge that the entire statement will be made a part of the record.

Mr. WICK. Yes, sir.

The CHAIRMAN. You are recognized, sir.

Mr. WICK. Thank you, sir.

Mr. Chairman and members of this distinguished and vital committee, I am Charles Z. Wick of Los Angeles, Calif. I graduated from the University of Michigan with a B.A. degree in 1940 and from Western Reserve Law School with an LL.B. degree in 1943.

At the present time I am president of United Convalescent Hospitals, Inc., which owns and operates 10 facilities throughout the country. I am a member of President Johnson's Task Force on Nursing Home Design and Improvement of Health Care and a member of the California Regional Council on Cancer, Heart Disease, and Stroke. I am also a director of National Council on Aging. Recently, I acted as a consultant to the Public Health Service on one of its nursing home research projects.

Today I wish to address my remarks to the inadequacies of the present medicare reimbursement formula, particularly as it relates to the problem of attracting construction moneys to provide sorely needed nursing home beds.

The principal problem connected with the construction of skilled nursing homes is the lack of an adequate reimbursement formula which will not only insure maintenance and operational costs of the facility, but which will also bring funds for construction of new beds into the marketplace.

The recent tight money situation in obtaining construction funds was a short-range problem. However, the short-term problem obscured the long-term problems. The tight money situation obscured the principal problem, which is adequate reimbursement for services performed.

We expect that as the tight money market loosens, nursing home construction will be reconsidered. However, it will be promptly rejected because of the totally unrealistic reimbursement formula under medicare.

Such would not be the case if an adequate reimbursement formula was provided; one which would offer the investor an opportunity to realize a suitable return on his investment commensurate with the risk he assumes in operating the facility.

Current financing programs could provide sufficient construction moneys given a proper reimbursement formula. Improvements in reimbursement would stimulate construction activity because operating and maintenance funds are the critical problem rather than construction funds.

The concept of reasonable cost reimbursement should be discarded. In its place there should be a formula based upon reasonable and customary charges for private paying patients in the particular area.

The present reimbursement formula will result in high cost to the Government because there is an absence of any incentive to curtail cost. The present formula which rewards high costs leads to inefficiencies.

However, the payment of reasonable charges would reward efficiency. There would be an incentive to bring down costs. The end result would be to attract capital from private and institutional

sources. Thus there would be response to the need for the construction of additional nursing beds.

The use of reasonable charges would obviate the necessity of the R.C.C. accounting system. It is in harmony with the Medicare Act which provides in section 1861(v)(1)(A) that private patients shall not bear the cost of those receiving payments under the medicare program and that medicare patients will not bear the cost of private patients. The use of reasonable charges would result in better quality care at a lower cost. It is a more realistic approach than is the plan of a reimbursement formula based upon costs.

The same arguments and solutions apply to the problem of increasing the availability of beds to nursing home patients as apply to the adequacy of care for nursing home patients. The principal obstacle to obtaining nursing home care is the inability to pay for the cost of the services.

Inadequacy of welfare payments to nursing homes has long been recognized as the major contributor to inadequate care and inadequate facilities. These same inadequate welfare payments are recognized as the major barrier to nursing home construction.

As a corollary, improvements in reimbursement would stimulate activity not only in construction but, more importantly, would stimulate better patient care.

Mr. Chairman, this Government's experience with "cost plus" contracts during World War II, as I understand it, was a sad one. In the end, a high excess profits tax was required as well as elaborate renegotiation and redetermination procedures.

As I understand it, as far as the Department of Defense and the General Accounting Office are concerned, cost-plus contracts are now not considered to be in the best interest of the public.

Therefore, I am amazed that the "cost plus" concept has been reestablished by the Department of Health, Education, and Welfare as a governmental policy. I am certain that the term "reasonable cost" sounded so reasonable that it was perhaps not adequately explored or studied.

Therefore, Mr. Chairman, I am asking this committee to undertake a consideration of a reimbursement formula based upon reasonable charges. I realize, however, that this cannot be done overnight and that, therefore, while such an approach is being studied, we must bend ourselves to improving upon what we have. I urge this committee to revise the present reimbursement formula along the following lines:

1. Reasonable costs for extended care facilities should include a return on the greater either of cost or the current fair market value of the facility determined in accordance with the principles of the American Institute of Appraisers or similar appraisals sufficient to attract capital investment.

2. In determining reasonable costs, the Secretary should consider, among other things, the need of extended care facilities for—

- (a) Replacement of plant and equipment.

- (b) Modernization and growth, specifically provisions through earnings for the long-range amortization of the principal of indebtedness incurred to finance modernization and growth.

(c) Research and comprehensive health planning.

(d) Reasonable rentals and reasonable interest-type returns on properties and money capital where supplied by the providers.

(e) Provisions for uninsurable risks and other business types responsibilities, as well as property and income and other taxes, where these cannot be shifted and are borne by proprietors.

(f) The payment of a return greater than that customarily paid to public utility companies because of the recognition that extended-care facilities operate in a competitive field subject to high risk.

(g) The Secretary should also consider the customary charges prevailing in the area for private paying patients.

(h) Insofar as any of these factors are applicable either to proprietary or to nonprofit facilities, the Secretary should consider such factors in determining reasonable reimbursement for proprietary and for nonprofit facilities, notwithstanding the fact that such application may result in different reimbursement for one type of facility than for the other.

3. In determining a reimbursement formula and allowance for costs, all legitimate business expenses or costs (including but not limited to compensation to owners) should be allowed in accordance with the regulations of the Internal Revenue Service and Armed Services Procurement Regulations.

Services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control should be includable as an allowance for cost at the cost to the provider as long as the charge by the supplier is in line with the charge for such services, facilities or supplies in the open market and is no more than the charge made under comparable circumstances to others.

4. The Secretary shall develop contractual methods to be offered to providers on a voluntary basis for the purpose of encouraging operating efficiencies without sacrificing high standards of health care.

It is my contention that were the present formula amended to include the above, then the inadequacies of the present cost plus formula (which permits little or no profit to proprietary facilities as well as no true growth factor to nonproprietary facilities and which, therefore, is unable to meet the great need for nursing home beds) would be overcome and funds for the construction of nursing home beds would be available.

Mr. Chairman and members of this committee, I thank you for granting me this opportunity to appear before you today. I shall attempt to answer any questions you may have.

The CHAIRMAN. Does that complete your statements?

Mr. PICKENS. That completes the statements of our witnesses, Mr. Chairman.

The CHAIRMAN. You had Mr. Harold Smith listed. Did he have a statement that you wanted to include in the record?

Mr. PICKENS. Not at this time.

The CHAIRMAN. Mr. Walker, do you have a statement you want to include?

Mr. WALKER. No, sir, I do not.

The CHAIRMAN. We appreciate having you gentleman with us. Are there any questions of these gentlemen? Mr. Betts.

Mr. BETTS. Mr. Wicks, the objections I have heard to the present reimbursement formula come mostly from the nonproprietary or non-profit nursing homes, claiming that it works to the advantage of the proprietary institutions as against the nonproprietary institutions.

I wonder if you care to comment on that and whether or not your proposal would eliminate that inequity that exists?

Mr. WICK. Well, sir, the difference in the reimbursement formula as between the nonprofit and the proprietary, as I understand it, is not really significant. The only differential in the two formulas is in the fact that the proprietary obtains one factor which is not available to the nonprofit; that is, a 7½-percent return on the equity. This 7½ percent return on the defined equity as regarded by the proprietary group is really not very attractive at all and is not greatly significant. That 7½ percent is not, as I said, available to the nonprofit.

However, there is a minuscule factor available to the nonprofit that conversely is not available to the profit; that is, as expenses are defined for this purpose the costs of the nonprofit are a basis against which 2 percent is available to the nonprofit for a special unrecognized growth allowance.

The parallel factor available to the proprietary is one and a half percent.

The second question you asked me, sir, was should these inequities be remedied. I would say that in my humble opinion the key goal we have here is to deliver to the patient optimum services at a reasonable price and I think that really it is rather irrelevant to distinguish who is the provider of those services and as a corollary distinguish the type of reimbursement available to him in fulfilling the primary goal of an efficient delivery of optimum services at the most reasonable correlated price.

Mr. BETTS. You represent both types of institutions, is that correct?

Mr. WICK. No, sir, I do not. We represent the proprietary group.

Mr. BETTS. I see. You represent both?

Mr. PICKENS. The association does; yes, Congressman.

Mr. BETTS. Are you acquainted with this suggested formula for reimbursement that Mr. Wick has presented here?

Mr. PICKENS. Yes, sir.

Mr. BETTS. Would that be acceptable to both the proprietary and the nonprofit?

Mr. PICKENS. It would in the nursing home field.

Mr. BETTS. That is what I mean.

Mr. PICKENS. However, in the hospital field my impression is that the American Hospital Association in all its State associations with the exception of one or two—Indiana is one of them—would rather have reasonable cost rather than reasonable charges.

Mr. BETTS. But as far as nursing homes are concerned you would say that this suggested formula would be acceptable both to proprietary and the nonprofit?

Mr. PICKENS. That is correct, Congressman, and, as you recall, Congressman Byrnes I believe introduced a bill along these lines about a year ago.

The CHAIRMAN. Mr. Ullman.

Mr. ULLMAN. Thank you, Mr. Chairman. I would like to have in the record, if you don't have it available now, information, on the

number of extended care facilities that have been approved across the country.

Secondly, I would like to have some indication of the number of facilities that are now under construction so that we get a picture of how rapidly this is expanding and whether it is expanding rapidly enough to meet the obvious needs. Then I would like to have some indication of the general cost pattern with respect to nursing home care and included in that an indication of the difference between the ordinary charges and the approved reimbursement.

Mr. PICKENS. We can supply that, Congressman Ullman. While we are on that subject, it is our understanding that the Federal Housing Authority has prepared a report on the effect of the reimbursement formula on the FHA construction program for nursing homes.

However, the report is not available to us, but I feel certain the committee can get it. I think that the Government agency that is dealing primarily with nursing home construction certainly has had some experience during these past 12 months, and certainly has some opinions.

Now, perhaps the experience hasn't been as broad as it might otherwise be because of the tight money market, but whether this report is good or bad for nursing homes I think it should be available.

Mr. ULLMAN. I would ask, Mr. Chairman, that whatever information they can supply us be inserted in the record at this point.

Mr. PICKENS. We will supply that information that you requested, sir, within the next few days.

Mr. ULLMAN. Thank you.

The CHAIRMAN. Without objection, the information will be included in the record.

(The following information was received by the committee:)

AMERICAN NURSING HOME ASSOCIATION,
Washington, D.C., May 8, 1967.

To: House Ways and Means Committee, Special Attention: Cong. A. Ullman.
Respectfully submitted: American Nursing Home Association.

Subject: a) Total Number of Extended Care Facilities Certified for Medicare.
b) Some Figures Relating to Nursing Home Construction.
c) An Index of the Difference Between the Ordinary Charges and the Approved Reimbursement.

Enclosed find pertinent material as per the request made by Congressman Ullman in course of the appearance of representatives from the American Nursing Home Association before the Committee on March 9, 1967.

a) See attached data sheet. In addition, it is estimated that since February 28, 1967, a possible additional 83 extended care facilities have been certified. Thus, when we speak of ECFs across the Nation, we round the figure off to 3,500 ECFs.

b) See attached data sheets.

c) As to the request for figures on the general cost pattern which would indicate the difference between the ordinary charges and the approved reimbursement, such figures are not now available.

The Medicare program of nursing home benefits began January 1, 1967. The law provides that for either the first twelve (12) months or the end of the fiscal year (June 30) the provider shall receive an interim rate based upon the historical costs of 1966. At the end of the first reporting period, a retroactive adjustment of charges will be made.

As a result, we do not have figures which would offer any significant index to the difference between actual costs and allowed reimbursement.

In fact, it is our contention that one of the most serious weaknesses in the present formula for reimbursement is that it requires the provider to play a kind

of "Russian roulette" in that it is not until months later that he actually learns if he is to be fully reimbursed for the already provided service.

FRANK G. ZELENKA,
Assistant Executive Director.

Title XVIII—Total certified nursing homes as of Feb. 28, 1967

Region I:		Region VI:	
Connecticut	171	Iowa	42
Maine	18	Kansas	45
Massachusetts	109	Minnesota	106
New Hampshire	6	Missouri	56
Rhode Island	13	Nebraska	17
Vermont	8	North Dakota	20
Region II:		South Dakota	8
Delaware	7	Region VII:	
New Jersey	55	Arkansas	33
New York	192	Louisiana	113
Region III:		New Mexico	15
District of Columbia	4	Oklahoma	18
Kentucky	26	Texas	173
Maryland	38	Region VIII:	
Pennsylvania	147	Colorado	78
Virginia	35	Idaho	20
West Virginia	17	Montana	34
Region IV:		Utah	25
Alabama	60	Wyoming	6
Florida	120	Region IX:	
Georgia	37	Alaska	6
Mississippi	13	Arizona	36
North Carolina	34	California	592
South Carolina	50	Hawaii	15
Tennessee	33	Nevada	10
Region V:		Oregon	64
Illinois	116	Washington	124
Indiana	41	National total	
Michigan	98	3,389	
Ohio	139		
Wisconsin	146		

Source: Social Security Administration.

Total nursing home construction, 1965

	Projects	Beds
Non-Federal	991	52,228
Federal	171	12,434
(a) Hill-Burton	105	6,776
(b) FHA	66	5,658
Total	1,162	64,662

Total nursing home construction, 1966

	Projects	Beds
Non-Federal	1,778	46,714
Federal	168	12,436
(a) Hill-Burton	123	7,694
(b) FHA	45	4,742
Total	946	59,150

¹ Estimated.

Construction figures, 1966

New projects.....	\$513, 800, 000
Additions.....	120, 200, 000
New beds (new projects).....	51, 380
New beds (additions).....	7, 770
Total, new nursing home beds.....	59, 150

Advance nursing home construction, 1967 (as of Jan. 31, 1967)

New projects (with 4,079 beds).....	44
Additions (with 402 beds).....	7

NOTE.—There are approximately 4,800 nursing home beds per month under construction in new nursing home projects.

Total square feet of floor space for 1967 health care market

I. New health care construction in 1967 should reach \$2,250,000,000 for work in place—	
For hospitals:	
New construction	\$733, 000, 000
Additions	811, 000, 000
Total for hospitals	1, 544, 000, 000
For nursing homes:	
New construction	583, 860, 000
Additions	122, 140, 000
Total for nursing homes.....	706, 000, 000
II. Average cost per hospital bed: ¹	
New construction	30, 000
Additions	25, 430
III. Estimated new hospital beds for 1967:	
New hospital projects	24, 435
Additions	31, 498
Total	55, 933
IV. Average square feet per hospital bed: ¹	
New hospitals	884
Additions	890
V. Estimated total square feet of floor space for 1967 hospital market:	
New hospitals	21, 600, 540
Additions	28, 035, 000
Total	49, 635, 540

Total square feet of floor space for 1967 health care market—Continued

VI. Nursing home data:

(a) Average cost per nursing home bed: ¹

New construction-----	\$10,500
Additions -----	15,700

(b) Estimated new nursing home beds for 1967:

New projects-----	55,605
Additions -----	7,780

Total -----	63,385
-------------	--------

(c) Average square feet per nursing home bed: ¹

New nursing homes-----	1,016
Additions -----	549

(d) Estimated total square feet of floor space for 1967 nursing home market:

New nursing homes-----	56,494,680
Additions -----	4,271,220

Total -----	60,765,900
-------------	------------

VII. Total square feet of floor space for 1967 institutional health care market:

Hospitals -----	49,685,540
Nursing homes -----	60,765,900

Total -----	110,401,440
-------------	-------------

¹ Source: Hill-Burton figures for 1965.

Long-term care construction without Federal aid—Number of projects and beds provided, Jan. 1, 1965, to Dec. 31, 1965

State	Total		Nursing homes		Nursing home units of hospitals		Chronic disease	
	Projects	Beds	Projects	Beds	Projects	Beds	Projects	Beds
Total.....	991	52,228	975	51,715	8	152	8	361
Alabama.....	20	1,169	20	1,169				
Alaska.....	1	18	1	18				
Arizona.....	9	601	9	601				
Arkansas.....	12	798	12	798				
California.....	152	9,225	151	9,198			1	27
Colorado.....	14	648	14	648				
Connecticut.....	29	1,508	29	1,508				
Delaware.....	5	235	5	235				
District of Columbia.....								
Florida.....	21	1,672	21	1,672				
Georgia.....	10	624	9	604	1	20		
Hawaii.....	1	74	1	74				
Idaho.....	7	198	6	195	1	3		
Illinois.....	37	2,214	37	2,214				
Indiana.....	41	1,942	41	1,942				
Iowa.....								
Kansas.....	24	1,620	24	1,620				
Kentucky.....	12	393	12	393				
Louisiana.....	29	1,570	29	1,570				
Maine.....	2	135	2	135				
Maryland.....	7	392	7	392				
Massachusetts.....	18	1,559	16	1,337			2	222
Michigan.....	39	1,728	39	1,728				
Minnesota.....	21	1,062	17	949	4	113		
Mississippi.....	4	132	4	132				
Missouri.....	18	1,388	18	1,388				
Montana.....	6	208	6	208				
Nebraska.....	25	1,403	25	1,403				
Nevada.....	1	35	1	35				
New Hampshire.....	3	130	3	130				
New Jersey.....	28	1,505	28	1,505				
New Mexico.....	2	188	2	188				
New York.....	34	2,005	34	2,005				
North Carolina.....	11	529	11	529				
North Dakota.....	5	293	5	293				
Ohio.....	31	1,757	31	1,757				
Oklahoma.....	58	2,090	58	2,090				
Oregon.....	16	845	16	845				
Pennsylvania.....	39	1,831	38	1,815	1	16		
Rhode Island.....	9	161	9	161				
South Carolina.....	15	404	15	404				
South Dakota.....	10	261	10	261				
Tennessee.....	17	585	16	585	1	0		
Texas.....	67	2,318	62	2,206			5	112
Utah.....	1	100	1	100				
Vermont.....	6	152	6	152				
Virginia.....	26	1,031	26	1,031				
Washington.....	18	1,619	18	1,619				
West Virginia.....								
Wisconsin.....	28	1,755	28	1,755				
Wyoming.....	2	118	2	118				
Guam.....								
Puerto Rico.....								
Virgin Islands.....								

Source: Division of Hospital and Medical Facilities, Program Planning and Analysis Branch, April 1967.

State	Total				Nursing homes				Units of hospitals			
	Number of projects	Number of beds	Total cost	Federal share	Number of projects	Number of beds	Total cost	Federal share	Number of projects	Number of beds	Total cost	Federal share
Total	123	7, 694	\$107, 685, 487	\$40, 750, 377	38	3, 087	\$44, 407, 036	\$13, 882, 706	84	4, 487	\$60, 022, 957	\$25, 904, 251
Alabama	5	124	1, 783, 414	1, 188, 996					5	124	1, 783, 414	1, 188, 996
Alaska	1	40	1, 500, 000	600, 000					1	40	1, 500, 000	600, 000
Arizona	6	392	5, 994, 737	2, 159, 620	1	50	487, 500	225, 000	4	222	2, 271, 743	971, 200
Arkansas	5	164	2, 683, 927	1, 715, 737					5	164	2, 683, 927	1, 715, 737
California	10	187	187, 275	62, 425					5	10	187, 275	62, 425
Colorado	2	121	2, 038, 499	529, 987	1	109	1, 882, 258	451, 867	1	12	156, 241	78, 120
Connecticut												
Delaware												
District of Columbia	1		130, 099	65, 049					1		130, 099	65, 049
Florida	4	355	3, 963, 145	1, 807, 427	3	316	3, 187, 568	1, 419, 638	1	39	775, 577	387, 789
Georgia												
Hawaii	1	51	651, 173	295, 200					1	51	651, 173	295, 200
Idaho												
Illinois	5	353	5, 260, 371	1, 642, 991	1	80	1, 280, 410	360, 000	4	273	3, 979, 961	1, 282, 991
Indiana	5	251	4, 496, 688	919, 732	5	251	4, 496, 688	919, 732				
Iowa					1	30	450, 000	220, 000				
Kansas	2	150	3, 904, 699	1, 162, 550					1	120	3, 454, 699	942, 550
Kentucky	2	87	1, 293, 581	727, 900					2	87	1, 293, 581	727, 900
Louisiana	3	308	2, 232, 800	1, 116, 400					1	308	2, 232, 800	1, 116, 400
Maine	1	30	384, 961	192, 480					1	30	384, 961	192, 480
Maryland	2	679	3, 199, 000	882, 167					2	679	3, 199, 000	882, 167
Massachusetts	1	67	918, 124	148, 877					1	67	918, 124	148, 877
Michigan	7	393	6, 052, 086	2, 928, 890	4	228	3, 862, 669	1, 750, 850	3	165	2, 189, 417	1, 178, 040
Minnesota	3	112	1, 611, 174	619, 006	1	42	446, 961	168, 000	2	70	1, 164, 213	451, 006
Mississippi	3	190	2, 438, 102	1, 624, 068					2	190	2, 438, 102	1, 624, 068
Missouri	1	125	909, 057	441, 000	1	125	909, 057	441, 000	3	190	2, 438, 102	1, 624, 068
Montana	1	19	412, 623	163, 608					1	19	412, 623	163, 608
Nebraska	1	20	265, 041	104, 614					1	20	265, 041	104, 614
Nevada	5	92	92, 130	46, 065					1	5	92, 130	46, 065
New Hampshire												
New Jersey	1	68	800, 000	288, 295	1	68	800, 000	288, 295				
New Mexico	2	124	2, 329, 796	709, 199	1	64	1, 139, 796	340, 456	1	60	1, 190, 000	368, 743
New York	2	54	935, 102	465, 358					2	54	935, 102	465, 358
North Carolina	3	192	5, 449, 152	1, 189, 406	2	156	4, 167, 391	843, 508	1	1	1, 281, 761	345, 898
North Dakota	8	512	7, 200, 405	3, 158, 702					8	512	7, 200, 405	3, 158, 702

Number of long-term care projects approved under the Hill-Burton program—Continued

FISCAL YEAR 1966

State	Total			Nursing homes			Units of hospitals		
	Number of projects	Number of beds	Total cost	Federal share	Number of projects	Number of beds	Total cost	Number of projects	Federal share
North Dakota.....	6	618	\$8,965,163	\$1,913,829	3	444	\$6,917,767	3	\$513,829
Ohio.....	4	117	1,336,662	664,333	3	87	947,012	1	193,575
Oklahoma.....	2	70	1,931,550	301,754	1	48	680,502	1	74,920
Pennsylvania.....	5	754	11,837,718	3,490,063	2	600	8,766,736	3	990,093
Rhode Island.....	1	50	871,000	435,500	1	50	871,000	5	1,550,000
South Carolina.....	6	218	2,724,000	1,816,000	1	30	399,000	5	1,269,018
South Dakota.....	1	50	538,037	269,018	1	30	399,000	5	1,255,549
Tennessee.....	5	162	2,827,670	1,255,549	2	221	1,402,800	1	538,037
Texas.....	2	221	1,402,800	601,750	2	221	1,402,800	5	2,827,670
Utah.....	1	15	241,886	120,943	1	15	241,886	1	538,037
Vermont.....	1	23	325,150	162,575	1	23	325,150	1	538,037
Virginia.....	4	193	3,043,110	1,495,278	1	50	744,885	4	1,405,278
Washington.....	1	72	1,123,532	278,680	1	50	744,885	1	1,278,680
West Virginia.....	1	130	2,490,048	1,019,326	1	50	744,885	3	719,326
Wisconsin.....	4	130	2,490,048	1,019,326	1	50	744,885	3	719,326
Wyoming.....	1	130	2,490,048	1,019,326	1	50	744,885	3	719,326
Guam.....	1	130	2,490,048	1,019,326	1	50	744,885	3	719,326
Puerto Rico.....	1	130	2,490,048	1,019,326	1	50	744,885	3	719,326
Virgin Islands.....	1	130	2,490,048	1,019,326	1	50	744,885	3	719,326

FISCAL YEAR 1965

State	Total			Nursing homes			Units of hospitals		
	Number of projects	Number of beds	Total cost	Federal share	Number of projects	Number of beds	Total cost	Number of projects	Federal share
Alabama.....	106	6,776	\$106,583,280	\$36,255,352	37	2,179	\$27,634,752	68	\$9,614,086
Alaska.....	2	60	810,365	535,174	1	28	281,703	2	535,174
Arizona.....	1	28	281,703	139,571	1	32	201,459	2	535,174
Arkansas.....	3	99	980,831	642,558	1	32	201,459	2	535,174
California.....	2	532	11,545,561	3,067,531	1	32	201,459	2	535,174
Colorado.....	3	132	2,092,098	310,205	2	132	1,972,527	1	18,848
Connecticut.....	1	87	1,102,408	480,010	2	132	1,972,527	1	18,848
Delaware.....	1	87	1,102,408	480,010	2	132	1,972,527	1	18,848

District of Columbia	2	91	1,612,203	806,102	2	74	845,000	417,500	2	91	1,612,203	806,102
Florida	4	163	1,895,845	939,298	2					89	1,050,845	521,768
Hawaii												
Idaho	1	64	1,728,854	392,470						64	1,728,854	392,470
Illinois												
Indiana	4	335	4,177,770	1,331,055						335	4,177,770	1,331,055
Iowa	2	58	1,024,003	1,496,282	1	32	455,794	210,000	4	26	598,209	276,262
Kansas	6	206	3,080,995	1,895,034	2	114	1,615,394	992,000	4	92	1,445,601	903,034
Kentucky	1	36	1,280,000	140,000						36	280,000	140,000
Louisiana	2	66	1,379,910	527,322						66	1,379,910	527,322
Maine	3	188	2,019,425	712,060	2	126	1,459,625	559,622	2	62	559,800	152,428
Massachusetts	3	313	7,034,215	1,280,016	3	223	4,455,515	390,016	1	80	2,578,700	350,000
Michigan	4	260	3,087,220	1,394,120	3	226	2,635,100	1,157,000	2	34	452,120	237,120
Minnesota	2	52	691,230	208,000						52	691,230	208,000
Mississippi												
Missouri	4	354	6,105,363	1,899,155	2	140	829,573	414,310	2	214	5,275,790	1,484,845
Montana	2	76	393,588	230,006	1	60	881,697	306,626	1	16	217,404	86,962
Nebraska	1	38	575,104	230,006						38	575,014	230,006
Nevada	32	32	779,060	389,530						32	779,060	389,530
New Hampshire	1	40	361,989	110,494	1	40	361,989	110,494				
New Jersey	2	216	5,105,990	942,340						216	5,105,990	942,340
New Mexico	2	50	506,098	249,637	1	50	309,098	151,137		1	197,000	98,500
New York	5	270	7,572,688	2,117,492						270	7,572,688	2,117,492
North Carolina	5	202	3,025,107	1,314,997	2	87	1,236,883	592,172	3	115	1,788,224	792,825
North Dakota	1	80	1,495,360	391,587	1	80	1,495,360	391,587				
Ohio	8	401	8,315,003	1,747,889	4	227	3,220,334	708,697	4	174	5,084,669	1,039,192
Oklahoma	3	78	908,021	452,640	2	63	644,040	320,650	1	15	263,981	131,990
Oregon	1	20	130,140	40,000	1	20	130,140	40,000				
Pennsylvania	4	376	6,084,659	1,572,663	2	225	1,957,472	644,360	2	151	4,127,187	928,303
Rhode Island												
South Carolina	2	117	1,726,573	1,041,551						117	1,726,573	1,041,551
South Dakota	2	89	986,075	342,367	2	89	986,075	342,367	2	89	986,075	342,367
Tennessee	1	54	750,064	340,639						54	750,064	340,639
Texas ²	5	877	6,624,086	2,036,420						609	4,274,645	1,761,700
Utah	1	75	833,649	415,774	1	75	833,649	415,774				
Vermont	1	35	397,400	196,200	1	35	397,400	196,200				
Virginia	1	169	2,805,312	1,519,652						169	2,805,312	1,519,652
Washington												
West Virginia	2	115	1,905,904	805,094	1	80	1,415,000	560,000	1	35	490,904	245,094
Wisconsin	2	151	2,418,195	956,504						151	2,418,195	956,504
Wyoming	1	60	895,228	445,658						60	895,228	445,658
Guam												
Puerto Rico	1	31	372,575	116,727						31	372,575	116,727
Virgin Islands												

Source: Division of Hospital and Medical Facilities, Program Planning and Analysis Branch, April 1967.

¹ Included in the total, 1 chronic disease hospital, in the State of Arizona, providing 120 beds, with a total cost of \$3,235,494 and a Federal share of \$963,420.

² Included in the total, 1 chronic disease hospital, in the State of Texas, providing 268 beds, with a total cost of \$2,349,441 and a Federal share of \$1,174,720.

The CHAIRMAN. Mrs. Griffiths.

Mrs. GRIFFITHS. Mr. Chairman, on page 3 of Mr. Morris' statement—page 3 it is in the summary in the back—you are talking about the payments going to a patient who doesn't even realize he has received a check and a guardian is appointed and intercepts the check.

May I ask you in your judgment how widespread this is? I didn't even realize that it occurred until this last week.

Mr. MORRIS. Congresswoman Griffiths, this is a relatively quite widespread problem, and you must remember that a very substantial number of patients in these facilities are the confused elderly. They are there because they are not competent in various intellectual functions, and within the usual geriatric facility—I use that term because the problem is primarily focused on this type of patient—the greater percentage of patients would present such a problem.

You would also encounter it, we do encounter it, in the case of people who have behavioral problems, perhaps the chronic alcoholic, this sort of type. It is a very widespread problem.

Then going to the problem of the conversion of the funds at the hands of a guardian, or member of the family, or some even ostensibly close friend, this by no means is an unusual situation. Does this answer your question?

Mrs. GRIFFITHS. May I ask could you at some point make a suggestion or would you approve a suggestion that when a patient has reached that point, if there is money enough, or if there is some other program that takes care of it, that the payments under social security be stopped?

Mr. MORRIS. I don't know all the fiscal intricacies here of what you suggest. I think that our suggestion is the appropriate cure to it. If it is a vendor payment then there would be no problem, remembering that the institution in every instance is accountable for the appropriate use of the funds.

Mrs. GRIFFITHS. Thank you very much. I was unaware that this problem existed, as I say, until this last week and discovered that it did exist and that it was probably common in such places; and it is unconscionable that money paid to the recipients be diverted to greedy children or neighbors or family and never be used on a recipient.

Mr. MORRIS. I agree. This is a good example of the kinds of practical problems that the administrator of a facility is encountering in the provision of services.

Mrs. GRIFFITHS. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Gentlemen, thank you for coming to the committee with this information. We appreciate it. Do you have something else?

Mr. PICKENS. No, sir.

The CHAIRMAN. Thank you for coming to the committee.

Mr. PICKENS. We wish to thank the committee for their indulgence. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Schmidt, come forward. Take a chair if you care to. Please identify yourself for our record.

**STATEMENT OF WILBUR J. SCHMIDT, CHAIRMAN, NATIONAL
COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS,
AMERICAN PUBLIC WELFARE ASSOCIATION**

Mr. SCHMIDT. Mr. Chairman, I am Wilbur Schmidt, the director of the State department of public welfare in Wisconsin and I am appearing here today as chairman of the National Council of State Welfare Administrators of the American Public Welfare Association.

The CHAIRMAN. Mr. Schmidt, we are pleased to have you with us this morning and you are recognized, sir.

Mr. BYRNES. Mr. Chairman.

The CHAIRMAN. Mr. Byrnes.

Mr. BYRNES. I would like to welcome Mr. Schmidt here and say to the committee that he is one of the very outstanding public welfare directors in the country and we are proud to have him in Wisconsin.

Mr. SCHMIDT. Thank you, Congressman Byrnes. I would like to bring to the committee's attention today the interest of the American Public Welfare Association in the bill H.R. 5710, especially in connection with material dealing with public welfare, child health, and social work manpower provision.

The CHAIRMAN. Mr. Schmidt if in the course of delivering your statement to us you omit any parts of it do so with the full knowledge that the entire statement will be made a part of the record.

Mr. SCHMIDT. Thank you, Mr. Chairman. As a matter of fact, in the interest of the time of the committee I do not intend to attempt

reading the statement verbatim. It will be my preference, if it please the committee, to instead summarize. I do so in accordance with a cover sheet which I think each of you has on the top of your papers. I will want to add a couple of points to that since it does not mention the one on public assistance that is not provided or would be provided under section 205 dealing with health care for patients who are not otherwise in need of the highly skilled type service and I want to mention also social work manpower which is not shown on that page.

With that in mind I would like to say first of all that the American Public Welfare Association is the national organization of State and local welfare departments and the individuals who work therein and that it has a system through committees dealing with problems of legislative developments in this field which leads to actions by the board of directors, of which I am also a member, and on each occasion of a new Congress and a new year we publish what we call our "Federal Legislative Objectives." One of these is attached to each of your papers and I would like to have that entered into the record.

The CHAIRMAN. Without objection, it will be.

Mr. SCHMIDT. These "Federal Legislative Objectives" have as their principal base the belief of the American Public Welfare Association that Federal-State grants-in-aid principles are basically sound and therefore should be fostered and developed in this area of public welfare administration, and that every effort should be made by both the Federal and State governments to bring assistance payments to an adequate level, and that separate categories for public assistance should be eliminated.

The Federal Government should participate financially under a single matching formula in the total range of welfare programs, including general assistance, foster care for children, and specialized services for children and youth. The social service functions of public welfare agencies should be more broadly defined in Federal law, and should not derive its authority solely from the public assistance titles.

It is against this background of objectives and purpose that I would like to comment on some of the items which appear in H.R. 5710.

The first one is this matter of adequate level and the provision in H.R. 5710 which calls for all States to pay full budgeted need. I think the committee is well aware from its past experience in this field that the practice across the country is to attempt the establishment of minimum adequate levels of dietary and housing, clothing and other kinds of needs of these families which are all very near the subsistence level, so that it would seem that if we are going to maintain this adequacy, even minimum adequacy, it makes little sense to then develop from that provision, after having made this determination, because of fiscal inability, which is the alleged position, that something like 75 percent, maybe 80 percent, maybe some other percent, of need is all that can be met.

Obviously, if the determination in the first place is minimum, as we believe it is, nothing but distress can result from the recipient being left with less than what was seen to be the minimum adequate level, so we think it is time that this kind of effort under the leadership of the Federal Government be undertaken, probably past time, because actually it is our view in the association that we are going to see a

continuation of the Federal-State partnership in this area, and if States are going to continue to have the role of administration, one of the essentials will be that we must get the program up all over the country to the minimum adequate levels.

If we do not do this it seems to us that gradually there will be increasing pressures to federalize this program.

Therefore, we share with the authors of the bill their purpose in the development of this minimum adequate requirement.

Secondly, we presume that the material under section 205 which calls for another matching provision for those patients who are in need of care in their own homes, or in appropriate institutions other than skilled nursing homes, as meaning that in some of these cases where the physician has so ordered and where the patient is in need of this kind of facility but does not require the full treatment as might be provided by an extended care facility, that this would allow the States to continue their present practice of maintaining these individuals in these kinds of facilities, and that the provision here, therefore, eliminates the maximum which would otherwise apply to the money payment and permits the States to, as it may now do in the skilled nursing home area, obtain a Federal matching according to title XIX percentage on the total cost.

We think that the protection there is that the physician must see that this is an adequate program or a service for the particular patient, and that the patient does not need a facility of a higher level of skill.

Going on, we observe under the medical assistance provisions of this bill a mention of a ceiling within which the States must operate in declaring the levels of income which will be permitted in the establishment of eligibility for medical assistance.

As we understand it, it is a provision that the income level provided by the State for medical assistance may not be more than 150 percent of the income level which is applied in the determination of eligibility for public assistance.

Again, we in the association understand the concern of the committee with reference to the administration and expenditure of the available funds in this area, and the need to put some kind of regulation on it so that all of us who are involved in the management of these affairs can operate within a framework which is controlled, and it looks to us as though the 150-percent idea would at the present time be manageable.

We are not aware of any State, so far as information has reached us at least, in which we feel its program would be in anyway affected at the present time, adversely affected at least, by the installation of this maximum limit. Possibly time will prove that some other percentage is indicated, but for now it seems to us to be the best solution.

Going on to the area of child welfare service, we are aware that in this bill there is provision to add a matching for the administrative and personnel expenses in connection with child welfare services, at least to 75 percent, provided of course that this applies to these costs in excess of a maintenance of effort level which is provided in the bill. While we endorse this as a step in the direction we would like to see this go, we feel that the provision of the bill is not enough. It has long been the view of the association that there could be no reasonable

difference seen between the child welfare service where it has to provide for the abused and neglected and dependent child, often in foster-home situations, possibly institutional situations, and the other kinds of services which are very similar in a family situation, aimed at the restoration of self-dependence. In the child welfare services our funding and staffing have too often limited us to the distress situation, that is, of putting out the fires, of seeing to room and board, and to whatever extent possible the staff could supply some counseling and services.

In many localities the coverage of child welfare services is too thin to have any real impact on the problems we are called upon to deal with. What we really need now is a basis of Federal financial participation that would equip the States and localities to expand and strengthen these services so that they can do a more effective job of preventing emergencies, of restoring children to their own families when possible, and of providing good quality care and protection to those who require it. The present Federal child welfare grants account for about 10 percent of the total State and local expenditures for child welfare services. We believe that the formula for financing this program should be on a par with that for the public assistance categories. This would be more nearly accomplished by the identical bills, H.R. 1977 and H.R. 5429, which have been introduced by Mr. Burke and Mr. Gilbert of this committee.

I refer next to the proposal to amend the community work and training programs.

We had seen some examples of State intervention in this area through work and training projects relief in years gone by and I am familiar with some of these demonstrations across the country where some very interesting results were obtained, so when the 1962 amendments were considered by this committee and by Congress the community work and training idea was introduced into the laws dealing with public assistance and some funding provisions were made available, but inasmuch as there was nothing there, and the States found it difficult to supply what was needed, to cover the cost of supervision of these projects, materials, tools, and some other things, there was not a great deal of movement in this area in the early years following the 1962 amendments.

It is a fact, however, that several States did pass special laws to enable them to cover the sponsorship costs of community work and training programs.

Then came the opportunity of title V under the OEO and a funding provision which was a joint one, an arrangement between that Office and the Welfare Administration, to enter into projects where some of the people whom we would have previously considered eligible for community work and training program might get this opportunity for training, for development of work habits, an opportunity to raise their level of skills, so they could become employable individuals.

That got off the ground and I think has now proven after a rather slow start, I think, that one answer for some people on the rolls in public assistance is this kind of opportunity.

We come now to 1967 and, as we understand it, we are now going to get into a three-way stream because, although it may be that the inten-

tion is to gradually phase out what is known as title V, at least for the moment we would see some continued financing under title V.

Now with the involvement of the Department of Labor, and especially as this gets around to what we had thought were the responsibilities for the welfare system in community work and training, our viewpoint, frankly, gentlemen, is that we are going to become again involved in extensive overlapping which in the end is likely to deter more than stimulate the development of these programs and it seems to us that it is totally unnecessary to complicate the machinery in this area to this extent.

So it is the view of the American Public Welfare Association that we ought to move ahead under section, I believe it is, 409 and develop the community work and training program as a facet of a public welfare program and avoid the mix which we think this bill would produce.

Now, I would like to say before closing on this point that we do not believe that there is any fault to the position of the Department of Labor that they should assemble under their general direction all manpower training types of programs, but what I think of when I think of community work and training is something different than I believe is usually the employment related job training type of activity.

I like to call it an effort on the part of the public assistance program to bring its recipients to the threshold of trainability. We are beginning here in these cases with people who have not yet formed work habits that are useful, skills that are useful, that have in very many of these instances no employability in modern times, connected with social problems, emotional problems, and health problems. And as we view community work and training it is a package approach that accounts for all these deficiencies in the individual and his family, and once we get this person to, I will repeat, the threshold of trainability, I think referral to the usual training programs is indicated and ought to be done.

I do not believe in copying programs, in paralleling programs. I think these are two different stages.

Consequently, I urge the committee to carefully consider the provisions and hope for your favorable consideration of some simplification of this process.

Now, lastly, social work manpower. We have had opportunity under our Federal child welfare funds to engage in training through the processes of stipends to graduate students. Most of us in the States have added some substantial amounts at the State level to this, but even in spite of that and with no difficulty whatsoever in obtaining high-quality students with interest in the training, the schools of social work are just not able, do not have the capacity, even were we in the position to provide for them the material, to provide training in sufficient dimension to keep anywhere near the demand.

Actually we circulated to our welfare administrators last year, even though the Department of Health, Education, and Welfare has a great amount of material on this, a request to report as to what they were seeing as their principal problem in this whole manpower area, and we have attached to our paper, which we would also like to have entered into the record, responses from several of these individuals.

All throughout those responses you will find the same thread of concern, and that is we just do not have sufficient training capacity in

this country in the field of social work to keep up with the demands that are piling up for people of this qualification in this field of service. And with the millions, the many millions, of public funds invested in the service programs and in people through the processes here of public assistance and related programs, it seems like a small venture to think in terms of some investment to enlarge our training capability so that we can improve the efficiency in these areas.

We, like all other businesses, need to have the advantage of the most highly trained and competent individuals, and it is just as important in the end product with which we are involved as it is in any other undertaking.

So we again urge to the committee this idea that, in addition to investing in the students, we also make an investment in the capacity of our schools of social work in this country.

In the area of child welfare where we did have one of our earlier opportunities to do training, we came up with the people that were the most highly trained at the time of the 1962 amendments, and it was there we finally had to turn to see where our qualified personnel could be located. We think this was lesson No. 1 in what happens when these programs become enlarged and when the staff shortages become acute.

I might add in connection with child welfare, while I am on the subject of the combination of financing of education and training of these people, as well as returning again to the point of Federal financial assistance and the cost of the services, I would like to add one more exhibit to the record which is the one titled, "Financing Public Child Welfare Services."

Now, Mr. Chairman and members of the committee, this covers the main points I had in mind emphasizing. We do have our full length statements which I chose, as I indicated earlier, not to read because of its length and I would like you to know that I and my associates sincerely appreciate this opportunity. We are aware of the careful deliberations of this committee over the years and the products which I think has come from it, which is a soundly developed basic program in this area.

What I do think we must do now is be sure we do not miss the opportunities that are before us to tool up for the 1970's and this is where we in the American Public Welfare Association stand. We see this program as a contribution to the maintenance of the individual responsibility and the productivity of America, both on the economic and humanitarian front, not as something that tends to reduce or in some way diminish individual responsibility.

I thank you very much, Mr. Chairman.

The CHAIRMAN. Mr. Schmidt, we thank you very much for your statement. The material you referred to without objection will be made a part of the record.

(The information referred to follows:)

STATEMENT OF WILBUR J. SCHMIDT, CHAIRMAN, NATIONAL COUNCIL OF STATE
WELFARE ADMINISTRATORS, AMERICAN PUBLIC WELFARE ASSOCIATION

Summary of statement

Testimony deals specifically with the Public Welfare, Child Health, and Social Work Manpower provisions of titles II, III, and IV of the bill.

The Association is generally supportive of these proposals, with the exception of the Community Work and Training Amendments, as constituting needed

next steps in the progression of legislative measures which this committee has developed for the improvement of the public welfare programs. States should be required to pay full budgeted need according to the standards which they have developed.

If it is necessary to place a limitation on federal participation in title XIX expenditures in behalf of the medically needy, the ceiling of 150% of the level of cash assistance is the best available solution.

Increased federal financial participation in the state child welfare programs is urgently needed. The proposal in H.R. 5710 is endorsed, as far as it goes, but it is not enough. The Association endorses H.R. 1977 and H.R. 5429, sponsored by Mr. Burke and Mr. Gilbert, of this Committee.

The Association has serious reservations with respect to proposed amendments to the Community Work and Training Program. They would result in unnecessary complexities, divided responsibilities, and administrative duplication.

Statement

I am Wilbur J. Schmidt, Director of the Wisconsin State Department of Public Welfare. I am pleased to have the opportunity of appearing before your Committee in my capacity as Chairman of the National Council of State Public Welfare Administrators of the American Public Welfare Association, and as a member of the Board of Directors of that organization.

The APWA is the national organization representing the field of public welfare. Our membership consists primarily of state and local public welfare agencies and individuals working or having an interest in public welfare programs. Through representative committees and the Board of Directors the Association has developed a statement of Federal Legislative Objectives, which with your permission, I should like to offer for inclusion in the record of this hearing.

Our general views on the measures that are needed to enable the public welfare agencies to provide adequate programs of assistance and services for the present and future periods are summarized in the following points which we submitted in 1965 to the Advisory Council on Public Welfare:

1. The federal-state grant-in-aid principle is basically sound, and should be retained.
2. Every effort should be made, by both federal and state governments, to bring assistance payments to an adequate level.
3. Separate categories for public assistance should be eliminated.
4. The federal government should participate financially under a single matching formula in the total range of welfare programs, including general assistance, foster care for children, and specialized services for children and youth.
5. The social service function of public welfare agencies should be more broadly defined in federal law, and should not derive its authority solely from the public assistance titles.

The President of our Association, Mr. Fedele F. Fauri, has said: "The inadequacies of our present public welfare system are ultimately traceable to three primary factors: Financing, multiplicity of programs and procedures, and manpower. The major recommendations of the Advisory Council deal with the difficulties associated with each of the primary factors, *within the context of an affirmation of national responsibility and leadership*. The resulting pattern of programs and services would create a strong, dynamic public welfare program adapted to the realities and exigencies currently facing our society."

These and other related measures which have been long advocated by our Association are embodied in the 1966 report of the Advisory Council on Public Welfare, which was established in accordance with the provisions of the 1962 public welfare amendments. After thoughtful consideration we find the Advisory Council's recommendations to be consistent with the Association's policy positions, and we accordingly commend this document as the most significant statement currently available containing guidelines for the future development of the public welfare programs in the nation. My comments with respect to the legislative proposals now under consideration will therefore be made in reference to this background.

While the public welfare provisions of H.R. 5710 fall short of the comprehensive objectives we endorse, in the main they are steps in that direction. If enacted they would result in significant improvements in the effectiveness and

adequacy of the public welfare programs. We recommend the authorization of a more comprehensive basis for federal financial participation in the child welfare program than is provided for in the administration bill, in order to bring it more into line with the public assistance categories. We also have serious reservations with respect to the proposed changes in the community work and training programs.

I should like first to comment briefly on the proposals to increase the levels of social security benefits. We do not have expert knowledge on the financing or administration of the social security system. The scope and adequacy of social security coverage, however, does have a direct bearing on public welfare programs, and is therefore of interest to us. It is our general view that social security coverage and benefit levels should afford adequate protection against all insurable risks to family and individual economic security. To the extent possible, therefore, social security is the preferable means for underpinning income, and consequently for reducing the necessity for public assistance.

Public assistance

Great progress has been made over the years in expanding the coverage and improving the adequacy of public assistance payments. However, the wide disparities that continue to exist among the states in this respect constitute the major shortcoming in the federal-state public assistance system. We strongly support the establishment of a federal requirement for the payment of the full amount of need as determined on the basis of a reasonable budget.

In principle there can be no valid objection against the payment of the full amount of need, as established by state standards, to eligible individuals and families. In view of the extent of federal financial participation in state public assistance programs, and the federal commitment to eliminate poverty, there is a sound basis for this to be established as a federal requirement.

At the time we recognize that for some states the burden of meeting full need would be greater than they can reasonably be expected to bear. If they are to be held to that standard, therefore, it will be necessary to provide an additional measure of financial support for states that are unable, through their own reasonable effort, to meet this standard. The authorization of special grants to assist those states in meeting these costs is both fair and necessary.

Public assistance programs are often criticized for being bound up in so many inflexibilities and limitations that the declared objectives of prevention and rehabilitation are nullified. It is claimed that a family must break up in order to be eligible for AFDC, and that the deduction of all earned income stifles initiative.

The bill contains a number of provisions designed to overcome some of these limitations and to provide the states with a wider range of resources to fortify their efforts in prevention and rehabilitation.

Our legislative objectives state: "Reasonable exemptions of earned income as an incentive to employment should be established on a uniform basis for all persons in need of assistance without regard to categories." The exemption of a portion of earned income in determining need is a sound and constructive measure. As the President has pointed out, the deduction of a dollar of assistance for every dollar earned amounts to a 100% tax on earned income. No one expects people who are self-supporting to be highly motivated in such circumstances and it is not realistic to expect more from those who are receiving assistance. A partial exemption can lend encouragement to gain experience that may ultimately enable an individual to become self-supporting. It is just as important to allow for an exemption of the earnings of a parent in an AFDC family as for the children, and we recommend the adoption of this provision.

The authorization of federal participation in assistance for unemployed parents should be continued on a permanent basis. Those states that have included this feature in their plans have found it to be a constructive measure, and we believe it will become more widely adopted if it is made permanent. The need of the substantial number of families who are covered by this provision is as genuine as that of the other eligible groups. Of perhaps equal importance is that it eliminates the pressures otherwise inherent in the AFDC program that result from the denial of assistance if an unemployed father remains in the home.

We support the proposal for federal financial participation for migratory workers. This group is too often cut off from the protection and assistance available to others, while in many instances their needs are the greatest.

We support the proposal to authorize federal matching on the title XIX formula for money payments to assistance recipients to pay for care in their own homes or in appropriate institutions other than skilled nursing homes. This plan would give the states the option of obtaining the same rate of federal matching for whatever type of care is most suitable to the individual circumstances of a recipient of Old-Age Assistance, Aid to the Blind, or Aid to the Disabled. It would remove the question of which alternative is financially the most advantageous for federal matching.

All possible encouragement should be given to the search for ways to improve the organization, operation, and services of the public welfare programs. The authorization of \$2 million a year to support pilot and demonstration projects has proved to be a most useful and effective device. An increased authorization, as requested, would yield even greater returns. These expenditures do not actually represent increases in the overall costs of the program. Rather, they represent the same money, used under more flexible rules, in order to try out new methods.

I wish to add a word with reference to the limitations that apply to federal financial participation in the public welfare programs of Puerto Rico, the Virgin Islands and Guam. We are aware that there are special factors involved in federal grants to these jurisdictions. The fact remains, however, that the levels of assistance which they are able to maintain under existing provisions fall far below any reasonable test of adequacy. As a matter of national policy, an effort should be made to remedy this situation. We recommend that some measure be devised to enable these territories to bring their assistance payments more in line with the needs of the recipients.

Medical assistance

The medical assistance program under title XIX, despite some complexities that have arisen with respect to financing, is meeting its promise as a major step in the direction of making comprehensive and good quality medical care available to recipients of public assistance and to the medically needy. We are well aware of the Committee's concern that some means must be found for placing limits on federal expenditures in behalf of the medically needy group. If the Committee finds a measure of this kind is necessary, we urge that nothing be done that would impose any specific dollar limits on state programs, or that would otherwise impair the open-end basis for federal matching, which is the cornerstone of the present federal-state system of public assistance.

We speak in support of the proposal now before you in H.R. 5710, which would restrict eligibility for medical assistance to individuals and families whose incomes do not exceed the state standards for cash assistance by more than fifty percent. This would offer a simple and yet effective formula for setting reasonable limits on federal participation in state medical assistance expenditures, and, at the same time, it would preserve intact the open-end principle, which has always been based on formulas rather than fixed dollar amounts. It would also serve to maintain a balance between levels for cash assistance and medical assistance. This, of course, could mean raising the level of cash assistance in one state as well as holding down the level of medical assistance in another. But since both programs are based on need there is an obvious relationship that should be held in some kind of balance. Ordinarily this will be satisfactorily accomplished by the states as they develop their own program plans.

We are not able to say that the proposed ratio will prove to be the right one in every instance. We expect this can only be learned by experience. But as far as we can discover it appears that this ratio would not require significant changes in any present state programs. In any case, each state would continue to determine for itself the overall level of cash and medical assistance to be maintained for its own recipients.

We know of no state that would have serious objections to this proposal, or that would be prevented thereby from maintaining an adequate medical assistance program. On the other hand, we have heard of no alternative proposal that would not meet with strong objections, if not on the basis of anticipated reductions in federal payments, at least on the basis of principle.

Thus, we are pleased to commend the present proposal as the best available solution to a difficult situation.

We support the proposal to establish an advisory council on medical assistance. We also agree that consumer interests should be well represented. However,

we think there might be a question as to whether the remaining ten positions give enough spread to include representation of the various health professions and services.

Community work and training

We have serious reservations with respect to the proposal in Section 204 of H.R. 5710, which would transfer to the Secretary of Labor the responsibility for maintaining and operating work and training projects for persons aged 16 and over who are recipients of Aid to Families with Dependent Children. We recommend that the existing authority under title IV, sec. 409 of the Social Security Act, (AFDC), be continued as it is, with the added provision for federal participation in the costs of project supervision, materials, and associated costs as proposed in the present bill.

Public Welfare agencies are frequently criticized for failing to provide services designed to prevent dependency and to help recipients of assistance to become self-supporting. If this is true it is not due to a lack of recognition or motivation on the part of the welfare agencies. Until very recently the public welfare agencies have not been provided with the authority or resources necessary to undertake many of these needed services. Over the years, however, they have looked to other agencies that might be better equipped to offer such services as employment training and counseling and placement that would meet the special needs of persons who are unable to compete for jobs because they are unskilled and inexperienced and perhaps illiterate. For the most part, however, the welfare agencies were unsuccessful in their quest from other sources for the specialized kind of services required to bring these severely disadvantaged people up from the "bottom of the barrel."

When the 1962 public welfare amendments were being formulated the public welfare agencies were consulted and they endorsed the proposal which was enacted as the Community Work and Training Programs. Some difficulty was experienced in putting these programs into operation because of the costs of supervision and equipment that had to be met entirely from state and local funds. Even so, a number of such programs were undertaken, and in some states special legislation was enacted to cover these costs, without any federal matching.

The value of work and training programs for public assistance recipients was further recognized in the Economic Opportunity Act, which was passed in 1964. Through title V of that Act, provision was made for the states and localities to receive full federal funds for training, supervision, and equipment. With this kind of financial support the states have had the needed resources to design and operate title V projects with strong training components. The public welfare agencies have responded well, and projects are now in operation in all states but one. They are beginning to show good results in enabling the long-term, hard-core unemployed to enter the labor market and to become self-supporting.

In 1966, however, new complications were introduced, when title V of the Economic Opportunity Act was completely rewritten, so that effective July 1 of this year the arrangement will be that Congress will appropriate funds to OEO, which will then transfer the funds to HEW, which will then reimburse the Department of Labor for providing training services under a new title of the Manpower Development and Training Act. Since the Department of Labor does very little training of its own, it must in turn purchase training services from still other agencies or contractors, which to a substantial extent, will be through arrangement with the Office of Education of HEW.

Moreover, the funds available for the title V projects for the current fiscal year have been cut back, just when the program was getting well established, in order, as we understand it, to make room for the new "critical impact" (Kennedy-Javits) programs, which are also to be administered by the Labor Department.

Now, in H.R. 5710, it is proposed that a Community Work and Training Program under the Social Security Act be "established and maintained by the Secretary of Labor." The Department of Labor would have first option to select the areas in which it would operate projects. The welfare department would be permitted to operate projects in other areas of the state if the Secretary of Labor certifies that it is impracticable for him to do so. Presumably the Department of Labor could thus exercise a veto on any state welfare project simply by withholding such certification.

Some states now have legislation of their own to enable them to cooperate with the federal government in conducting community work and training projects. Would the Labor Department now decide whether the state could operate any of

these projects, and if so, which ones? Would the Labor Department decide where the state's percentage of materials and supervision costs would be committed?

From this bill it is not clear to us who is going to be responsible for putting up the 10 percent state matching for the costs of materials and supervision. We wonder whether the state welfare departments will be expected to ask their legislatures for these funds for the Labor Department's projects.

It is perfectly clear, however, where the Labor Department will get its federal funds. It will be through a pipeline to the authorizations under sec. 409 and the proposed new section 410 of the AFDC title of the Social Security Act. It is less clear to us, however, how much control the Secretary of HEW will have over how much he must "transfer from time to time" to the Secretary of Labor "to enable him to carry out the purposes of section 410."

We are aware that the Department of Labor believes it should have responsibility for all manpower training programs, and in principle we do not object. However, the people who are enrolled in the community work and training programs require a wide range of coordinated and supportive social services of which the actual job training is often only one part. This means that the welfare agency should maintain a continuing relationship with these people until they are employed regardless of who provides the job training. The present proposal would inevitably result in parallel administrative networks at all levels of government—federal, state and local—one for the welfare agencies and one for the Labor Department. Then coordinating machinery and procedures would have to be set up at all levels. In addition to that there is now the complicated three-way responsibility for administering the Economic Opportunity title V program which involves OEO, HEW, and Labor. We can only hope that this will not be cited as one more example of overlapping and confusion in the public welfare programs.

The responsibility of the public welfare agencies for managing the work and training programs has been limited and divided in a number of ways. We could not get full federal funding for our own training programs, but we got it through OEO, along with their control of policy. Then beginning next July the Labor Department will take over training responsibility for title V. Now it is proposed that Labor operate the training programs for unemployed parents, but the bill will be paid from AFDC funds. The public welfare agencies, however, will continue to carry ultimate responsibility for providing assistance and social services for the individuals and families who are to receive this training. We are concerned that the interests of these individuals and families will become fragmented among the unresolved jurisdictions and objectives of three federal administrative agencies and two legislative committees in each house of Congress. The public welfare agencies also find it frustrating to be asked to develop these programs, only to have them taken away when they begin to show signs of success.

With reference to the OEO programs, the President's budget (p. 132) says: "The Work Experience program (title V) for needy adults, now run jointly by the Departments of Labor and Health, Education, and Welfare, will be reduced in 1968 and gradually replaced by an expanded community work-training program under new legislation for public assistance recipients."

We ask that this projected plan be carried out through the existing section 409 (AFDC) with the added authority to pay the costs of materials and supervision, as can now be done through OEO title V. We ask that the welfare agencies be given sole responsibility for this single program at all levels, including responsibility to utilize the resources of Labor and OEO, and others, as needed and as may be feasible. If that is not possible, we recommend that the welfare agencies at all levels be relieved of their responsibilities, financial as well as operational, for the work and training programs. It would then be our hope that the specialized training services needed by persons now served by the Economic Opportunity Act, title V, and the AFDC sec. 409 programs, would be maintained by the Department of Labor, or some other agency, and that they would be freely and readily available for persons referred by the welfare agencies.

Child welfare services

The bill proposes to authorize federal payment of 75 percent of that part of the state expenditures for salaries and training of child welfare personnel which represents an increase above the present level of state expenditures for those purposes. This would bring to the states a greatly needed measure of encouragement and support for their efforts to build up their child welfare services.

At the same time, however, I have the responsibility to report to the Committee that an even greater degree of federal financial participation is needed in order to enable the public child welfare agencies to discharge the responsibilities that are placed upon them. The provisions that more realistically meet demands of today are embodied in the identical bills H.R. 1977 and H.R. 5429, sponsored by Mr. Burke and Mr. Gilbert of this Committee.

In brief, these bills provide for federal matching at a flat 75 percent for costs of all salaries and training of child welfare personnel, and variable matching ranging from 50 to 83 percent for all other purposes, such as day care, foster care, and administration. There is nothing really original or startling in this proposal. It would simply place the method of financing child welfare services on an equal footing with the public assistance categories, which we believe is fully justified. This measure has been carefully studied by our Association and by public welfare agencies throughout the country. It is fair to say that it is supported by a more broadly based and urgently felt consensus than any other proposed child welfare legislation in our experience. This is not a sudden reaction. These proposed provisions represent the culmination of a number of carefully considered recommendations that have been put forward over a period of years. They are quite similar to the recommendations contained in the 1959 report of the Advisory Council on Child Welfare Services, which was authorized by the 1958 Social Security Amendments. They are also reflected in a statement on "Financing Public Child Welfare Services," which was endorsed by our Association last year, based upon a two-year study by our Committee on Services for Children and Youth. Mr. Chairman, with your permission I offer this statement for inclusion in the record.

The public child welfare service programs are responsible for providing a wide range of social services for children and their parents. While these services are not a part of the public assistance programs, to a very large extent they are concerned with children from low income groups who are the victims of such hazards and disadvantages as neglect, abuse, abandonment, family conflict, illness, personality disorders and mental illness. The methods and resources utilized by the child welfare agencies include care in foster families and institutions, placement for adoption, day care for children of working mothers, homemaker services (which provide help in the home during illness of parents or other emergencies), protective services for children who are neglected or abused, arrangement for specialized medical or mental health services, and family counseling. Child welfare workers also enlist the help and cooperation of other agencies in behalf of the children they are serving, such as churches, schools, courts, physicians, hospitals, police, probation and parole, and many others.

I am sure you will agree that these services are of fundamental importance. Unfortunately they have never been adequately supported or developed, and with the burgeoning social problems of today we are now faced with the necessity of catching up in one large step.

The initial purpose of the child welfare grants was to provide funds to stimulate the development of state and local services. For that reason the authorization was placed in the maternal and child welfare title of the Social Security Act. Included in the same title is the authorization for grants for Maternal and Child Health and for Crippled Children's Services. Collectively, these authorizations under title V of the Act have, in our estimation, produced as great a return, dollar for dollar, as any grant-in-aid program that the federal government has undertaken.

A number of state "children's bureaus" and other public child welfare programs had been in existence, in various stages of development, prior to 1936 when the federal grants first became available. One of the effects of these grants was that the existing state child welfare programs were given a clearer definition and identity, and in states where they had not existed before they were then established. Usually they were placed, together with the federally aided public assistance programs, in the state departments of public welfare. With the exceptions of Kentucky and Illinois that pattern continues to prevail throughout the states.

The authorizations and appropriations have increased substantially over the years. For the first full fiscal year—1937—the appropriation was about \$1.37 million and for the current fiscal year it is \$46 million. The fact is, however, that the amounts of these funds bear no direct relationship to the size of the problem or the needs of the states. Today the states are spending on the order

of \$400 million per year on their child welfare programs, of which federal funds account for roughly 10 percent.

The authorizing language says that these funds are to assist the states in establishing, extending, and strengthening child welfare services, which they most certainly have done. But the program has not been designed to carry a proportionate share of the ongoing cost of state operations. In fact, until 1958 the law actually restricted the use of these funds by states to areas predominantly rural and areas of special need, and the amount allocated to a state was determined, not on the basis of its child population, but on the basis of its *rural* child population. The removal of these restrictions has enhanced the effectiveness of the federal grants in stimulating the states to extend and strengthen their programs. But much remains to be done.

The Children's Bureau deserves a great deal of credit for encouraging the states to strive for high standards of professional competence in their child welfare programs. A substantial portion of these funds has been used to pay for the professional education of social workers employed in the public child welfare agencies. As a result of this policy the child welfare programs have built up a corps of professionally qualified personnel in every state, which, although far too small, constituted for many years the great majority of the professionally qualified personnel in the state and local public welfare agencies. In fact, when the public assistance programs began to tool up to implement the social service provisions of the 1962 welfare amendments, and needed qualified staff in a hurry, the quickest place they could get them was from the child welfare services. Many of the supervisors and administrators now in charge of the public assistance service programs were trained with child welfare funds.

The definition of child welfare services in the federal statute is a model of excellence, and is a sound basis for developing an adequate program. It provides room for flexibility and innovation without the rigid requirements that sometimes inhibit the operation of service programs. Because of chronic and severe staff shortages, however, it has too often been necessary for the child welfare agencies to devote most of their time and efforts to emergency situations—"the baby on the doorstep"—with the result that their activities have been involved to a disproportionate extent in the placement of children for foster care and adoption. And even these services must at times be carried out with too much haste. Many children now in foster homes could be returned to their own families if the time-consuming counseling services were available to assist in restoring domestic stability. And many other foster home placements could have been averted. At the same time there is the paradox of not having enough suitable foster family homes available, in part, or at least because of not enough staff time to seek them out and not enough money to pay adequate rates.

The federal act also requires a state to make a satisfactory showing that it is "extending the provision of child welfare services in the state, with priority being given to communities with the greatest need for such services after giving consideration to their relative financial need, and with a view to making available by July 1, 1975, in all political subdivisions of the state, for all children in need thereof, child welfare services provided by the staff (which shall to the extent feasible be composed of trained child-welfare personnel) of state public welfare agency or of the local agency participating in the administration of the plan in the political subdivision."

We can say with confidence that the state and local public welfare agencies are wholly in accord with this objective, and will commit their resources, as they are able, to its attainment. It is said that one-third of the counties do not now have the services of a full-time child welfare worker, and that only one-sixth of all child welfare workers have social work degrees. But those figures do not tell the whole story, because one full-time worker is a meaningless standard of measurement. In a small rural county it might well be adequate, but in an urban center it is only a little better than nothing. So the actual population coverage today is probably more like one-fourth than two-thirds, which means there is still a long way to go to meet the 1975 dead-line for state-wide coverage of services.

The federal participation currently pays for about 10 percent of the cost of state and local child welfare programs. The federal standards for 1975 would cost a great deal more than the present program level, but according to the existing authorization there would by no means be a proportionate increase in the federal contribution. On the basis of the existing and currently projected levels

of federal financial participation, these standards, however desirable, are more in the nature of federal hopes than federal requirements. We are not objecting to the standards. We strongly support them, and we believe that most states would make an effort to attain them regardless of the level of federal support. But the states need much more help than they are now getting.

We most assuredly do not oppose the increased federal financial participation in child welfare services as proposed in H.R. 5710. As I have indicated earlier, this would result in genuine improvements in the public child welfare programs. But we also feel responsible for presenting to you the facts and program needs as we see them. We sincerely commend to you the larger step as being urgently needed and fully justified.

Child health

I wish to express a special word of commendation in behalf of the group of related proposals to expand and improve health services for children of low-income families, and for increasing the authorization for funds for training professional personnel for these specialties.

Although we have greatly extended our health care programs, we realize all too well that health problems of children from low-income backgrounds too often are not only untreated, but undetected. The existing programs, such as the Crippled Children's Services, the Maternal and Child Health Services, and Medical Assistance, have the capability of providing or making available these needed services. It is therefore sound and proper to build them up, as this legislation proposes to do. These expanded programs are needed not only for their humanitarian purposes, but also because they are prudent measures for the prevention of dependency in future generations.

Social work manpower and training

We endorse the proposed program of grants to schools of social work.

Public welfare agencies are faced with a critical shortage of the qualified personnel needed to carry out their assigned responsibilities. At the same time the graduate schools of social work are operating at the limits of their capacities, and there are not enough undergraduate schools offering courses in social work to meet more than a fraction of the needs of the agencies. As matters now stand the demands for even greater numbers of trained personnel will increase at a greater rate than the capacities of the schools.

The chief concern of the public welfare agencies is that the personnel shortage stands in the way of the full implementation of the social service provisions which were established by the 1962 Public Welfare Amendments. We regard those amendments as the most important single legislative step that has been taken to improve and strengthen the federal-state public welfare system. State and local agencies are aware of the far-reaching possibilities of these provisions and are seriously working toward their fulfillment.

Public welfare agencies, however, have always been afflicted with a dearth of professionally qualified personnel. Following the enactment of the 1962 amendments they moved to overcome these shortages in a number of ways, one of which was to greatly increase the number of stipends for the professional training of staff. But many other fields, both governmental and private, are also competing more keenly than ever for personnel. One result is that the graduate schools are now generally filled up, and authorizing more stipends too often results in more names on the waiting lists of the schools instead of more trained workers.

Steps are being taken to enlarge the graduate schools and to start new ones, as well as to add more social work training courses in the undergraduate schools. But the needs are so great that existing financial resources can only partially meet them, and there are no present indications that the situation will be significantly relieved without new sources of funds.

The federal government is making a major investment in social service programs, not only through public assistance, but also in such fields as mental health, mental retardation, vocational rehabilitation, health services, child welfare, juvenile delinquency, and corrections. In a very real sense the return on this investment is in jeopardy because of the lack of a sufficient number of personnel qualified to carry out these programs. Therefore this proposed legislation should be regarded as a measure to facilitate the attainment of these program objectives.

We recognize that the manpower problems of one special field, such as public welfare, cannot be solved in isolation from other competing fields. All of the

employers are fishing in the same manpower pool. But the needs of the public welfare agencies are particularly critical, and since most of the legislative base for their programs is in the Social Security Act, it is desirable that these training funds also come from that source. Moreover, we assume that these funds would be administered by the Welfare Administration, which is the agency most closely associated with both the public welfare agencies and the schools of social work.

We recognize, too, that the amount of funds that would be authorized by this proposed measure would not in itself solve the manpower shortage. But this amount would be of inestimable value in stretching the capacity of existing facilities, in giving an added boost to new schools that are trying to get started, and in getting more social work content into the undergraduate curriculum. These funds would be especially useful in hiring additional teachers and in paying the costs for expanded field training positions.

The manpower needs in social welfare have been studied by the Department of Health, Education and Welfare, and by the Council on Social Work Education. We do not have any additional statistics or documentation based upon formal studies. A few months ago, however, we invited the administrators of state departments of public welfare to submit a brief statement on their personnel requirements and to comment on the need from their viewpoint for a program of grants along the lines of the present proposal. Even though we already knew the results and recommendations of the various studies and reports that had been completed, we were deeply impressed by the tone of urgency, supported by solid background information, which marked the replies we received. We have compiled pertinent excerpts from these letters, representing nearly half the states. Since this compilation gives concrete examples of actual situations in the states I believe it would be useful to the Committee in considering this proposal. With your permissions I offer this document for inclusion in the record.

My foregoing comments are based largely on information obtained from these letters. They emphasize again and again that the social service programs of the public welfare agencies are being held back because of personnel shortages. Some of the comments would also appear to indicate that the routine statistics may not tell the full story. In some states, for example, positions that should actually require graduate professional training are listed as requiring only an undergraduate degree because they recognize that professionally qualified people cannot be found. Some needed positions have simply been dropped from the staffing plans because it is unrealistic to expect that they can be filled. This suggests that if the number of available personnel were to be increased, some states would list even more vacancies than they now show.

We believe that a program of grants to schools of social work, as envisioned in this bill, would make an effective contribution toward relieving the present critically limited resources for training of personnel for public welfare agencies.

Conclusion

Mr. Chairman, on behalf of the American Public Welfare Association I wish to express appreciation to you and this Committee for the opportunity of appearing before you. Through a long series of progressive and constructive steps this Committee has followed a continuing course of improving and strengthening the legislative base for the public welfare programs. We believe that the major features of H.R. 5710, with the exceptions we have noted, are the proper next steps in this progression.

FEDERAL LEGISLATIVE OBJECTIVES 1967, AMERICAN PUBLIC WELFARE ASSOCIATION

(Prepared by a special ad hoc committee, approved by the Board of Directors,
December 8, 1966)

PREAMBLE

The highest purpose of a democracy is to promote and safeguard the well-being of its people. This is best realized by assuring for each individual a fair opportunity to fulfill his potentialities and aspirations and the means for living in decency and dignity.

This freedom of opportunity has been maintained for the great majority of Americans while at the same time, this has become the first nation with the re-

sources required to protect all of its people from the scourge of poverty. By firm resolve and intelligent utilization of all resources, the opportunity can also become a reality for all to achieve their fullest potential and to contribute as they are able to the general welfare. And for those who are less able there can be the assurance of an adequate share of the fruits of the nation's abundance.

Public welfare is a principal instrument of the people, through their government, for facilitating more equitable opportunity for participation by all in the social and economic benefits now enjoyed by the majority. The present scope of public welfare programs is a reflection of the gaps in the social and economic fabric of the nation. It is essential to the well-being and security of the nation that increased emphasis be placed upon all measures to prevent social problems, especially in families whose income is inadequate for the needs of their children. Such measures must include the elimination of racial and religious discrimination and the development of full and unrestricted opportunity for employment at a suitable wage. It must also include full and unrestricted opportunity for adequate housing, education, social insurance, and medical care.

The American Public Welfare Association, while focusing in this document on federal legislative action needed for the fulfillment of the commitments of public welfare, holds the following positions which are basic to the continued development of an effective system for securing and protecting the basic rights of people.

A. Effective measures should be maintained to promote and protect the economic security of individuals and families.

1. Full employment at adequate wages should be the goal for all persons who are employable and whose services are not required in the home.

2. Social insurance programs should be improved and expanded to afford adequate protection against all insurable risks to family and individual economic security.

3. There should be study and action to develop a national plan for adequate income maintenance for individuals and families whose economic security cannot be protected through full employment or social insurance.

B. Solving human problems, promoting social competence and shaping the community in ways that produce satisfying and happy family life are complex undertakings. These efforts require the expertise of many disciplines and the deep involvement of a wide variety of governmental and voluntary agencies and of individual citizens. Public welfare, charged with heavy responsibilities for helping people and communities solve and prevent problems, has a continuing close contact with people in trouble. Public welfare has developed specialized knowledge and skills in its relation to these people. But public welfare does not represent the only resource for solving complex family and social problems. Therefore, public welfare must join with other governmental and private agencies in providing appropriate leadership to marshal the resources for developing the social and economic, environmental and community resources essential to the full and satisfying participation of all people in society.

C. Discrimination in housing, education, and employment on account of race, creed, color or national origin violates the principles of a democracy. Discrimination creates ugly slums and ghettos, substandard schools, depressed income, and all of their consequent results which contribute to family and individual breakdown. Discrimination must be attacked through legislative, administrative, and educational efforts. In addition, continued study of methods for better community planning must be pursued.

D. Citizen understanding, interest, support and participation are vital for the fullest development of public welfare programs. Special emphasis should be given to the involvement of those people who are the consumers of public welfare services.

E. Federal, state, and local units of government all have important roles as partners in achieving basic social benefits for all people through public welfare programs.

1. All governmental jurisdictions must cooperate in providing the leadership and the professional, technical, and auxiliary personnel so essential in carrying out their respective responsibilities.

2. The states and their subdivisions have the primary responsibility for developing and administering effective public welfare programs, including a broad spectrum of services.

3. The federal government has the obligation to develop nationwide goals, guides and standards for program content, to use its constitutional taxing

power to equalize the financing of public welfare, and to assure an adequate minimum standard of income maintenance and services throughout the nation.

4. All units of government have the obligation to plan, develop, and administer their programs consistent with the principle of public welfare as a right.

F. Public welfare programs must be made more comprehensive and flexible than is possible through a rigid categorization of people and programs in order to meet the needs of individuals, families, and communities for:

1. Comprehensive community-wide social services for all individuals, families, children and youth, irrespective of their need for financial aid.

2. Financial assistance for all who need it, irrespective of whether available social services are requested or provided.

3. Comprehensive medical assistance for all families and individuals who are without means to provide adequately for their own medical care.

G. Public welfare programs must be based on humanitarian concern for all individuals and families. Therefore, these programs should be administered in such a way as to insure in practice that the rights, dignity, responsibility, and independence of people are respected, and that social services and financial and medical assistance are universally available and readily accessible, without regard to race, color, creed, national origin, residence, settlement, citizenship, or circumstances of birth.

The specific objectives which follow represent long-range and interim goals based on these basic positions and the recognition of public welfare's responsibilities in relation to the families and individuals who seek its help in preserving family life; arranging for needed substitute care and protection, especially for children and the aged; providing health services and the other specialized services required in addition to, or in lieu of, financial assistance.

PUBLIC WELFARE PROGRAMS

Scope of Program

A comprehensive nationwide program of social guarantees, with nationwide standards set by the federal government, should be established. This program should require that adequate financial aid and social services be available to all who need and desire them as a matter of right.

In the interim—

1. The consequences of economic dependency and social disaster are not restricted to persons in arbitrarily established categories. The comprehensive nature of public welfare responsibility should therefore be recognized through federal grants-in-aid for assistance for all needy persons.

2. Federal financial aid should be available to assist states in carrying out public welfare responsibility for preventive, protective, and rehabilitative services to all who require them, irrespective of financial need, including grants for comprehensive state-wide planning.

3. States should have the option to administer federal funds for assistance and services by categories, by a combination of two or more of the present categories, or by a single comprehensive program covering all needy persons.

4. One of the serious obstacles to the attainment of the objectives of public welfare programs for prevention of dependency and the restoration of the dependent to self-sufficiency is the lack of qualified personnel. In order to reduce this deficiency the existing educational resources must be expanded and new ones established. It is clear that this can be attained only through substantial federal support.

5. The money-payment principle has proved an efficient and constructive method of providing assistance to needy people and should be preserved.

6. All public welfare programs in which the federal government participates financially should be administered by a single agency at the local, state, and federal level.

7. Legal services are essential in assuring the fundamental rights inherent in public welfare. Federal financial aid should be available in order to provide comprehensive legal services for people with limited income.

8. Provision should be made for federal financial participation in costs of short-term or emergency assistance extended on the presumptive determination of eligibility pending full verification.

9. Reasonable exemptions of earned income as an incentive to employment should be established on a uniform basis for all persons in need of assistance without regard to categories.

10. In all welfare programs in which the federal government participates financially the imposition of the following should be prohibited: (a) any citizenship requirement; (b) any "legal settlement" or duration of residence requirement; (c) any lien provision or other requirement which exacts from any person, during his lifetime or the lifetime of his surviving spouse and minor or otherwise handicapped children, involuntary repayment for any assistance legally paid to him; and (d) any requirements for relatives' financial responsibility, except that of parents for a minor child and spouse for spouse.

11. The legal status of a child's birth or the suitability of the home environment should not be a factor in determining eligibility for AFDC. If such circumstances are detrimental to the well-being of any child, they should be dealt with through appropriate social services and judicial processes on the same basis for all persons regardless of the need for financial assistance.

12. Federal financial participation for comprehensive medical assistance should be available for all medically needy individuals.

13. Federal financial participation in AFDC should be increased to a level that will enable all states to provide an adequate standard of assistance. Extension of this program to include needy families with an unemployed parent should be mandatory in all states.

14. The interstate placement of children in family homes for permanent care or adoption should be regulated by federal statute.

15. There should be established within the Welfare Administration one consolidated program for the prevention, treatment, and control of juvenile delinquency.

16. Federal financial participation should be available to the states for assistance to needy disabled persons without regard to any age requirement or any requirement that a disability be permanent and total.

17. Services for the aged should be financed through a grant-in-aid system of subsidy to the states providing for mandated minimum social services for the elderly throughout each state, without reference to financial need.

18. The federal government should participate financially in the costs of state and local emergency welfare services in natural as well as man-made disasters.

19. Federal law should require the establishment and maintenance of state standards of health and safety for housing rented to assistance recipients.

20. Work opportunities at prevailing wages, not competitive with regular jobs in private or public employment, and with other appropriate safeguards to protect the health and dignity of the worker should be available to persons for whom jobs cannot be found and whose continued unemployment contributes directly to a need for public assistance. Such work should, where appropriate, provide training and be directed toward the preservation or development of work skills.

Financing Adequate Programs

Essential to the financing of adequate and comprehensive programs is a uniform and simple plan for federal-state sharing in costs of all public welfare programs, including the programs in Puerto Rico, the Virgin Islands and Guam. The plan should provide for equitable and reasonable fiscal effort among states and should recognize the relative fiscal capacity of the federal and state governments.

In the interim—

21. The continuation of the federal open-end authorization is essential to a sound state-federal fiscal partnership in all aspects of public assistance. Since it is not possible to predict accurately the incidence and areas of need, flexibility and comprehensiveness are necessary in financing public assistance programs.

22. Federal participation in public assistance should be authorized at a level sufficient to assure, for all needy individuals, adequate standards of maintenance and comprehensive medical care.

23. In order to achieve proper and efficient administration of public welfare programs, adequate and qualified personnel is indispensable. Federal financial participation in administrative costs must be increased. In addition, separate formulas for reimbursement of services and administration should be eliminated.

24. Federal reimbursement of administrative costs should be extended to cover the purchase or construction of public welfare office buildings.

25. Federal aid for public welfare should be on the same basis for Puerto Rico, the Virgin Islands, and Guam as for other jurisdictions. The annual dollar limitations on federal participation for these jurisdictions should be removed without further delay.

26. Provisions should be made for federal matching of costs of administration, services and foster care in state and local child welfare service programs, including services for the prevention, treatment, and control of juvenile delinquency, on a basis comparable to the matching now available in public assistance. In the meantime, the full amounts authorized for Child Welfare Services under Title V, part 3, of the Social Security Act should be appropriated.

SOCIAL INSURANCE PROGRAMS

Broadening the scope of coverage, liberalizing the benefits, and extending coverage to additional insurable risks are essential if the social insurance programs are to fulfill adequately their primary function of underpinning income.

In the interim—

Social Security

27. The federal social insurance program should be strengthened. Among the needed improvements are: (a) making benefit payments more adequate, especially those based on low wage levels, which frequently result in need for supplementation through public assistance; (b) providing for automatic adjustment of the level of benefits in accordance with the cost of living; (c) keeping the amount of earnings creditable for contribution and benefit purposes in line with current earning levels; (d) broadening the scope of disability insurance protection to include the extension of coverage to survivors and disability beneficiaries under the health insurance programs; and (e) extending coverage to earners and their dependents still excluded. To the extent that changes to improve the OASDI program increase its costs, the income to the system should be increased to insure its continued financial integrity.

Unemployment Insurance

28. The Unemployment Insurance program, as a basic method of meeting the income-maintenance needs of unemployed people, should be strengthened. Among the needed improvements are: (a) establishing federal standards which would assure more adequate benefit payments, including benefits for dependents; (b) extension of coverage to earners still excluded; (c) provision for a minimum duration of benefits; (d) provision for more equitable eligibility conditions; (e) provisions for less restrictive disqualification requirements; and (f) an increase in the amount of earnings creditable for contribution and benefit purposes in line with current earning levels.

There should be federal provision on a permanent basis for extended benefits during any period of extended unemployment.

Other Social Insurance

29. The federal government should provide leadership, funds, and research in order to give more effective aid to the states in the improvement of state workmen's compensation programs. Study should be given to ways of improving and extending, on a sound social insurance basis, temporary disability insurance benefits and workmen's compensation programs, with emphasis on planning for effective medical care and vocational rehabilitation.

PLANNING, RESEARCH, AND DEMONSTRATION

30. The federal government should provide continuing leadership and adequate funds for research and demonstration, for special projects directed toward the reduction of dependency and the strengthening of family life, and for the development of social indicators and other methods of measurement of social progress.

31. The Welfare Administration should maintain a national social welfare research center for collecting data, conducting research, disseminating information and providing national stimulation and leadership in developing new knowledge of human needs and resources.

32. The federal government should provide leadership, funds, and research for the promotion of health and the prevention of sickness and disability contributing to dependency. Federal health programs should establish guides to encourage and enable state and local health departments to make a more effective contribution to broad programs of preventive health services and physical restoration.

33. The amounts authorized for maternal and child health and crippled children's services should be increased and provision should be made for aid to other handicapped children.

34. Public welfare has a responsibility to assure that comprehensive rehabilitative services are made available to persons who require them. Adequate funds should be available to public welfare agencies to carry out their responsibility to restore individuals to self-care and to strengthen family life.

35. To prevent eligible individuals from being deprived of vocational rehabilitation services, such services should be strengthened so that all vocationally handicapped persons who present reasonable possibilities of attaining a vocational objective would be served. States should be permitted to designate the state agency which can most effectively administer the vocational rehabilitation program.

36. The substantial progress which has been made in federal legislation for the mentally ill and the mentally retarded should be projected further through sound and timely implementation, and with adequate financial support.

37. Federal programs should provide more effective aid to help meet the needs of migratory workers and their families.

38. There must be bold and innovative measures for improving the quality of life in the nation's cities, including the expansion and strengthening of programs, for the renewal and revitalization of blighted areas and for providing adequate housing for low-income families. Close coordination must be maintained, however, between the physical construction and restoration programs and the social services. Therefore, the public welfare programs should be enabled to deal more comprehensively and flexibly with urban social problems.

FINANCING PUBLIC CHILD WELFARE SERVICES (AMERICAN PUBLIC WELFARE ASSOCIATION)

(This policy statement was developed and approved by the Committee on Services for Children and Youth, December, 1965 and adopted by the Board of Directors, June 13, 1966)

"Provisions should be made for Federal matching of costs of administration and services in state and local child welfare services programs, including the costs of maintenance in foster care of all children requiring such care, on a basis comparable to the matching now available in public assistance."—APWA Federal Legislative Objectives, 1966.

Prior to the 1962 Amendments, Federal grants under Title V, Part 3, of the Social Security Act were available for the limited purposes of "establishing, extending and strengthening" services "for the protection and care of homeless, dependent and neglected children, and children in danger of becoming delinquent." Now, under the 1962 Amendments to Title V, Part 3, Federal grants are available to assist the states in the development of comprehensive programs of child welfare services.

PROVISIONS OF THE 1962 AMENDMENTS FOR CHILD WELFARE SERVICES

Specifically, the 1962 Amendments provide that such grants are to be used for providing "... social services which supplement, or substitute for, parental care and supervision for the purpose of 1) preventing or remedying, or assisting in the solution of problems which may result in the neglect, abuse, exploitation or delinquency of children; 2) protecting and caring for homeless, dependent or neglected children; 3) protecting and promoting the welfare of working mothers; and 4) otherwise protecting and promoting the welfare of children, including the strengthening of their own homes where possible or, where needed, the provision of adequate care of children away from their own homes in foster family homes or day care or other child care facilities." (Sec. 528). The basic legislation

in regard to "establishing, extending and strengthening" services still pertains, but the definition of the children to be served has been broadened and made more specific by the new definition of public child welfare services. Moreover, greater responsibilities have been placed on state agencies in "establishing, extending and strengthening" child welfare services.

CONDITIONS OF ELIGIBILITY FOR FEDERAL CHILD WELFARE SERVICE FUNDS

The 1962 Amendments to Title V, Part 3, impose new and ambitious conditions of eligibility for Federal child welfare funds, as follows:

1. Services are to be provided in all political subdivisions of the state by 1975. In extending these services, priority is to be given to communities with the greatest need for such service, after giving consideration to their relative financial need.

2. Services are to be "for all children in need thereof" requiring an aggressive approach in locating and determining children and families in need of child welfare services.

3. The services to be provided, as indicated by the new definition, must be comprehensive in nature, directed toward strengthening the child's own home where possible, or when this is not possible, providing a variety of substitute living situations to meet the individual needs of children who must live away from their own parents.

4. Services are to be provided to the extent feasible by trained child welfare personnel.

LIMITATION OF FEDERAL FUNDS FOR CHILD WELFARE SERVICES

A statutory limitation of \$60 million for the fiscal year ending June 30, 1970, and for each succeeding fiscal year, is imposed on the amount of Federal child welfare services funds which may be appropriated by Congress for distribution on a matching formula to the states. Presently the expenditures of state and local funds for child welfare services are estimated to be in excess of \$246 million.¹

To achieve the program goals envisioned by the express terms of the 1962 Amendments, the Federal government must shift the purpose of its grant program from that of stimulating state effort to that of contributing to the total cost of the public program of child welfare services in a manner equal or comparable to the Federal grant for aid and services to needy families with children (AFDC).

FEDERAL SHARE IN THE AFDC PROGRAM

Under Section 403, Title IV, of the Social Security Act, the 1962 Amendments increased the Federal share in the cost of providing services in the AFDC program from 50 to 75 percent. States can now receive three Federal dollars for each state dollar spent to provide comprehensive social services, such as: social group work, homemaker services, care by foster families, medical and legal consultation, vocational education. It is proposed that Congress enact similar provisions for Federal grants for child welfare services.

THE ADVISORY COUNCIL'S RECOMMENDATION

Convinced that the Federal grant system should be extended, the Advisory Council on Child Welfare Services in its report of December 28, 1959, to the Secretary, U.S. Department of Health, Education, and Welfare, and to the Congress, recommended that—

The Federal government pay part of the total cost of public child welfare services of each state and other cooperating jurisdictions through Federal grants-in-aid on a variable matching basis, with provisions for an open-end appropriation, and with continuing encouragement to establishing, extending and strengthening of such service.

The statutory provision for an open-end appropriation should be formulated in such a way as to assure that there would be no decrease of a particular state's expenditure of state or local money for child welfare services as determined by the fiscal year 1960 or some other base year.

¹ Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, *Fact Sheet—Services for Children, How Title V of Social Security Act Benefits Children*, 1964.

The foregoing was the only one of the Advisory Council's 15 recommendations that was not subsequently implemented. However, it is noteworthy that much of the reasoning offered for the recommendation found its way into the substance of the 1962 Amendments. The Council pointed out, for example, that a new Federal-state partnership in financing was necessary in order that the states could develop and expand comprehensive services and so that the Federal government could encourage equalization of services within and between states and provide a basis for overall program standards. As already indicated, the 1962 Amendments affirmed these necessities but ignored the corollary that the Federal government should carry joint responsibility with the states for the necessary financing.

PRESENT SERVICES AND PATTERNS OF FINANCING

An examination of the extent of child welfare services in the states today and the varied patterns of financing them confirms the 1959 report of the Advisory Council:

There is a wide variation in the extent to which states have organized to provide the specialized services within the definition mandated by the 1962 Amendment. The reasons for these variations include the state's history and traditions in serving its children, its philosophy of state-local responsibility, the part played by voluntary agencies, the economic situation and tax base, and the extent of citizen involvement in public policy issues.²

The rate of children receiving child welfare services from state and local public child welfare services ranges from Michigan's 11 per 10,000 child population, to 184 per 10,000 child population in the District of Columbia.³ Most states estimate that only from one-fourth to one-half of the children known or estimated to be in need of services are receiving them.⁴ Since about 750,000 of the nation's 64 million children under 18 years are currently being served,⁵ the total number of children potentially in need of service can be estimated to range from one and one quarter to three million.

Lack of adequate financing has resulted in some states having poor foster care and in others having none at all.

Problems of state legislation for child welfare financing include lack of specific statutory base for financing child welfare services apart from other services; a statutory base for direct services but not for administration; no identification of funds for child welfare in the appropriation act, or no statutory base or appropriation of state funds for locally administered public child welfare agencies.⁶ Similar problems characterize local financing for child welfare services.⁷

Enormous discrepancies in the proportion of state and local sharing in the costs of child welfare services and in per capita expenditures clearly demonstrate the differences in the quality and quantity of child welfare services being given by the states.

Percentage distributions range from Alabama's 40.4 percent Federal funds, 59.6 percent state funds and no local funds; to Ohio's 5.9 percent Federal funds, 1.4 percent state funds and 92.7 percent local funds.⁸ Per capita expenditures vary from 47 cents in Idaho and Texas to \$11.12 in the District of Columbia.⁹

SHIFT IN STATES' PROPORTION OF FINANCING

Emerging from this welter of discrepancies, however, are identifiable trends in providing services and in financing. State plans show acceptance of public welfare's responsibility to extend its range of services and to serve more and more children in need. Except for appropriations states in all instances now have an adequate legal base for extending services in terms of the 1962 Amendment mandate.

² Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, *Goals, Problems and Progress in Child Welfare*, Child Welfare Report No. 13, 1964, p. 19.

³ Department of Health, Education, and Welfare, *Welfare in Review*, Statistical Supplement (Washington, D.C.: Government Printing Office, 1964), p. 28.

⁴ *Goals, Problems and Progress*, op. cit., p. 20.

⁵ *Welfare in Review* (July 1963), pp. 10-16.

⁶ *Goals, Problems and Progress*, op. cit.

⁷ *Ibid.*, p. 26.

⁸ *Welfare in Review*, Statistical Supplement, 1964, op. cit., p. 29.

⁹ *Child Welfare Statistics* (Series No. 75), Children's Bureau, Welfare Administration (Washington, D.C.: Department of Health, Education, and Welfare, 1963).

Within a recent ten year period¹⁰ Federal, state and local expenditures for public child welfare services more than doubled:

[In millions of dollars]

Fiscal year	Total	Federal funds	State funds	Local funds
1953.....	120.3	7.4	46.3	66.6
1963.....	267.8	26.1	135.8	105.9

In terms of percentage, one can more easily see the decided changes in source of funds over the past ten years.

[Percent]

Fiscal year	Federal funds	State funds	Local funds
1953.....	6.2	38.4	55.4
1963.....	9.8	50.7	39.5

There has been almost a reversal in the child welfare financing roles of state and local authorities. While on the average the state now bears the greater proportion of financing, there can be little or no expectation of any great gains from this shift. It is the position of most states that additional funds, particularly in the areas of welfare and education, must come from the Federal government.

SUGGESTED MEANS FOR OBTAINING NECESSARY FUNDS

Several alternatives for gaining the Federal funds necessary to achieve the program objectives mandated by the 1962 Amendments have been suggested.

One such approach would be to identify services such as homemaker service and foster care as Child Welfare Services and seek additional Federal financing for them. Another would be to secure Federal matching for fully trained child welfare staff, or perhaps for certain categories of fully trained staff; for example, child welfare supervisors. A more comprehensive suggestion calls for Federal matching at 50 percent across the board for services and 75 percent for services provided by professionally qualified staff.¹¹ Of these suggestions, only the last mentioned holds any hope of meeting the need.

VALUE IN THE CURRENT METHOD OF FEDERAL CHILD WELFARE SERVICE GRANTS

Even though the current method of Federal grants to states for child welfare services will not result in the needed services, these grants have demonstrated a special value over the years. Although small in relation to state and local expenditures, the grants have had great effect on the strengthening and extension of services. Many state and local governments have assumed ongoing responsibility for new programs and services as the result of demonstration projects financed by these grants. Major research projects have been developed through modest expenditures from the Federal grants for sound research designs. State agencies, using their Federal grants, have been able to respond quickly and flexibly to changing needs and propitious circumstances that may not have been anticipated during the budgetary process.

THE AMERICAN PUBLIC WELFARE ASSOCIATION POSITION

It is the position of the American Public Welfare Association that child welfare as a service program should continue to receive the present Federal Grants for Child Welfare Services and should, in addition, receive Federal financial sup-

¹⁰ The 1953 figures were estimated from data made available to the committee by the Children's Bureau and summarized by C. Wilson Anderson, a member of the Committee and Commissioner for the Office of Children and Youth, Pennsylvania Department of Public Welfare. The 1963 figures are from *Child Welfare Statistics* (Series No. 75). No. 9, Table No. 31 (Washington, D.C.: Department of Health, Education, and Welfare, 1963).

¹¹ *Goals, Problems and Progress*, op. cit., pp. 24-25.

port in conformance with principles already accepted by Congress for other programs such as Aid to Families with Dependent Children. Such Federal support would broaden the base of financing child welfare services in keeping with the need and equalize services both within and between the states. This could be achieved by amending Title V, Part 3, of the Social Security Act, authorizing the Secretary of the U.S. Department of Health, Education, and Welfare to pay states for amounts expended as found necessary by the Secretary for the proper and efficient administration of public child welfare services. Specifically, this would add to present Federal Child Welfare Services Grants a Federal share of 75 percent of state and local expenditures for the services provided as defined in Section 528 of Title V, Part 3, and for their administration and for the training of personnel employed or preparing for employment by the state agency or its participating local agency. In the event the state's approved plan for public child welfare services does not meet all the services prescribed in Section 528, the Federal share would be equal to 50 percent of the sums expended for services, administration and the training of personnel.

No state presently gives or is able to provide adequate child welfare services. The lack of coverage and the lack of basic services to sustain, strengthen, supplement or substitute for parental care, bear shameful witness to the enormous gaps between this Nation's stated goals and values with respect to children, on the one hand, and its level of efforts and achievements on the other. The Federal government cannot do otherwise than respond.

The American Public Welfare Association, therefore, makes the following recommendations:

1. The Federal government, through a matching program, should assist states and localities in financing *all* public child welfare services and other costs associated with such services. The formula should be the same as the current 75-25 percent basis used by the Federal government in matching other public welfare service programs.

2. Open-end appropriations should be authorized for such matching grants, with provision that there be no decrease of state and/or local expenditures for such purposes.

3. The current Federal Child Welfare Services grants to states should continue because they are an essential method for encouraging innovation and experimentation, for enabling initiation of services which are new in given states and localities, and for achieving desirable flexibility in the continuous development and provision of adequate welfare services to children.

4. The Federal government should make further study of methods of administration which place more reliance on broad, rather than highly detailed, measures of accountability.

SOCIAL WORK MANPOWER

The following are excerpts from letters written by administrators of state departments of public welfare to the American Public Welfare Association, with reference to proposed federal legislation to authorize a program of grants to schools of social work:

Alaska.—The Alaska Division of Public Welfare would like to go on record as wholeheartedly supporting this bill. . . . We have entered into a cooperative arrangement with the University of Alaska to assist them in the establishment of an undergraduate social work curriculum and we know that the University is very enthusiastic about the possible eventual establishment of a graduate school within the next few years. We know that the University of Alaska would be most concerned about this legislation and would support it completely.

Alaska has many problems in securing qualified staff necessary to effectively implement the 1962 Public Welfare amendments. Recruitment of qualified staff is probably the most discouraging aspect of my work. With few educational opportunities for Alaskans who are interested in pursuing a career in social work, it has been necessary for us to look to other states for supplying us with social workers. This is a far from satisfactory situation, since there is such a nationwide shortage of qualified social workers. This is why we are so vitally interested in the University of Alaska's program and why we are working so closely with them.

Arkansas.—I strongly favor this resolution, since we are unable to fill the vacancies which exist among the ranks of County Directors, County Visitors,

Field Supervisors, and Supervisors of Staff Personnel in the State Office due to two facts: One is that we cannot find qualified people and the other is that if we could find qualified people we could not pay them the salaries it would take to get them.

We certainly need a School of Social Work here in Arkansas. As to where it would be located, I am uncertain—but I would say in Little Rock, since this is the center providing more facilities for field placements. Let me emphasize (and I cannot be strong enough in my recommendation) that we recommend that this resolution be passed which will provide funds to assist in the establishment of a School of Social Work here. We are now spending over \$200,000.00 per year in educational scholarships sending people out of the State to Schools of Social Work located in these other states.

California.—Last year our Management Analysis Bureau developed MSW staffing projections for our 58 county welfare departments through 1975 to provide for evaluating and comparing requirements and recruitment. This study, which could not take into account the staffing needs of the medical assistance program under title XIX of the Social Security Act, estimated that the 1975 county welfare department social worker requirements will be 13,320 positions, including 5,560 with professional education. In order to achieve this objective it appears that almost 10,500 MSW recruits will be needed * * *. Assuming increased requirements of other users commensurate with those of county welfare departments and continued competition among the users, it appears that requirements cannot be met unless the number and capacities of graduate schools of social work are vastly increased.

In addition, our county welfare departments will need to recruit a minimum of 2,000 new workers a year qualified with B.A. degrees from now until 1975 * * *. Obviously, undergraduate social work programs need to be expanded both for recruitment to the field and for the preparation of students for graduate study.

Delaware.—In Delaware, we are handicapped in carrying out the programs for which we are responsible, because we lack qualified personnel to accomplish a constantly enlarging task, even though most staff labor with dedication under constantly increasing pressure. Although usually we are able to fill casework positions requiring only a bachelor's degree, only about one percent of these people have had any training in social work. The shortage of professionally trained supervisors and caseworkers is critical in our agency, not only because our salaries are not competitive but because Delaware has neither a graduate nor an undergraduate school of social work. Our University of Delaware does not even have an undergraduate sequence in social work, although trained people in the field of social services have been in short supply for years.

The authorization of a federal appropriation would help to develop and expand existing schools, which would probably help Delaware to some extent. If this money could be used also to set up a professional graduate school of social work in one university of each state, or at least an undergraduate school, this would benefit the Delaware public welfare program much more * * *. Under any circumstances, we are in favor of the bill.

Florida.—The most critical shortage is in the positions requiring Master's degrees. There have been members of our staff who are qualified for graduate education and for whom stipends were available, but who could not gain admission to schools because of limitations in enrollment.

Illinois. (Department of Public Aid): The recent study published by the Department of Health, Education and Welfare statistically corroborates the critically felt need for increased manpower in social welfare agencies throughout the country. The demand and need for social workers far exceeds the present complement of workers available and the present capacity of schools to prepare workers for the field. We, therefore, agree that the Federal government must intervene to provide leadership in the development of, or expansion of, education in social work at the undergraduate and graduate level.

Illinois (Department of Children and Family Services).—Since its establishment in 1964, the Department's workload had increased steadily at a rate which far exceeds the availability of qualified personnel. Progress toward realization of the mandates of recent federal and state legislation in the field of public child welfare services demands that progressively greater numbers of qualified personnel be added to the supply of social work manpower each year. The Department seeks to meet the increasing need for qualified staff through an employment-

education program which provides financial assistance for eligible graduate students in social work and child development. During the 1966-1967 school year, ninety persons will attend school under this program which is financed through United States Child Welfare funds. Each year students have had greater difficulty in gaining admission to graduate schools of social work. Since we anticipate need to increase the numbers of persons on this program by at least twenty-five students per year for several years, we are vitally concerned that expansion of the schools' capacities keep pace with our growing needs, as well as those of all public and private agencies.

The Social Work Manpower Training bill represents a significant forward step in seeking to solve the chronic problem of manpower shortage in the field of social work. We endorse the support of this bill by the American Public Welfare Association.

Kentucky.—The most current estimate of social work vacancies in the state at the present time, for all departments, is about 1500. These vacancies represent a combination of workers who have completed their degree in either undergraduate or graduate social work.

* * * The Kent School of Social Work at the University of Louisville is the only accredited graduate school of social work in the state. Because of limited facilities it can turn out less than fifty graduates a year. A committee has recommended the establishment of a new graduate training program at the University of Kentucky, but no funds are available for the research and planning which is necessary prior to such establishment.

There is not doubt that federal funds could be used to advantage in helping the expansion of present facilities for training social workers and that such funds could help in the establishment of new facilities in the area.

Louisiana.—An expansion of the capacities for undergraduate schools is needed. There is no regular undergraduates school of social work in this state. However, our public undergraduate colleges are overcrowded and in need of additional funds, both for faculty and buildings. Several of them do have undergraduate sequences which are valuable for beginning workers. Expansion of graduate schools is needed. One of the problems, in addition to those of classrooms and faculty, is the lack of academic field work opportunities. We work with both of the schools in this state to give as much field work as we feel we can. We could expand our capacity for field work training in New Orleans if we had space for more students and if the schools had adequate faculty instructors.

Maryland.—We now have a total of 98 positions requiring the MSW, either vacant or temporarily filled with persons without graduate training. To the above must be added an estimate of the number leaving the program annually from positions requiring an MSW and those new positions expected to be created as the result of increased caseloads in the future.

We have 76 persons attending graduate schools of social work in the coming year. There were 64 in the program last year. We hope to gradually increase this number in the years to come, but may encounter resistance for budgetary reasons. These graduates are required to serve two years in our program in return for the financial aid they receive (approximately \$4,000 per year). The schools of social work in the Maryland area inform us that they have waiting lists of qualified applicants due to the shortage of space, faculty and field placements. The University of Maryland School of Social Work is steadily expanding its capacity, so that to date we have not faced the problem of having qualified students who are unable to find a school of social work that would accept them. However, we expect that this situation will arise in the near future unless the schools are given financial aid to help them increase their enrollments.

We believe that this legislation would be helpful in expanding graduate social work education and in the development of undergraduate education. In order to expand existing educational facilities, establish new ones and develop new patterns and methods of education, funds must be available for faculty, recruitment and training, additional student stipends and development of the curriculum at both educational levels.

Minnesota.—There is no question that an expansion of the capacity of graduates from graduate schools is needed. Each year we have a number of applicants for stipends for graduate study who although acceptable for admission to various schools end up on waiting lists because the school capacity is limited. Between 15 and 20 percent of the applicants for stipends from our Department for graduate study in social work for the school year beginning this fall ended

up with a "waiting list" status * * *. One of the chief reasons for the inability to graduate more students is the insufficient funds to pay the kind of salaries necessary to attract additional qualified faculty. Although we are fortunate in Minnesota in that we have progressive undergraduate schools that are developing social work sequences, lack of sufficient faculty at that level is also a problem.

Missouri.—At the present time the Division of Welfare has approximately two hundred vacancies for positions in the administrative, supervisory, and caseworker classifications. In addition to filling these vacancies, the agency will need to employ an estimated additional 664 caseworkers, 146 supervisors, and 110 clerical staff in order to fully implement the adult services program * * * our main problem will be in filling vacancies in the administrative and supervisory positions in view of the minimum educational requirements set by HEW. * * *

I believe an expansion of the capacities of both undergraduate and graduate schools is needed to help meet the growing need for qualified staff in public welfare. I believe the legislation as in the proposed social work manpower bill would be very helpful in meeting the present and future manpower needs of the Missouri Division of Welfare.

Nevada.—With the possibility of adding new programs in the next biennium, the recruitment problem will become even more acute. We have had positions requiring an M.S.W. vacant for 1½ years and see no change in the picture in the immediate future.

We have been working closely this year with the Chancellors and faculty at the University of Nevada at Reno and Southern Nevada University in Las Vegas. They are actively working with us and other agencies in planning for the establishment of an undergraduate sequence in social welfare, hopefully by the Fall of 1967. The University has also expressed interest in moving as quickly as possible in establishing a graduate school.

One of the perennial problems is, of course, funds. Passage of this legislation would provide a much needed source of funds. In our situation, this would be most helpful.

New Jersey.—Very recently we again had occasion to review the present staffing situation of this Department and it was obvious that one of our greatest difficulties is the recruitment and maintenance of personnel to fill those critical positions requiring a master's degree in social work. In New Jersey this Department is able to evaluate the total impact of the problem, since we are concerned not only with the community programs of public welfare but also with the efforts within our various institutions to serve the patient and inmate population so that they may adjust to a return to community living.

Beyond the present situation, we are necessarily concerned with planning for full extension of the AFDC program, assistance and services to patients in our hospitals for mental diseases and tuberculosis, strengthening our community mental health clinics, and formulation of a title XIX program. However skillful our planning may be, we must recognize that the effective implementation of these various programs is basically dependent upon our ability to recruit qualified personnel in social work and other disciplines.

New Jersey will be increasing its demands upon the undergraduate and graduate schools to prepare young men and women for effective service in public welfare, and it is only logical that we should express strong support for any legislative measures which will aid the schools in their efforts to meet this increasing demand. For these reasons we do not hesitate to express support of federal grants for social work manpower.

North Carolina.—An expansion of the capacities of both undergraduate and graduate school is needed.

Oregon.—Our present and future needs for additional staff require that we recruit on a continual basis. The turnover, statewide, in our professional casework positions increased the past year from 26% to 37%. We employ between 24 and 30 new caseworkers every six weeks. Based on indications from last year's recruiting efforts, we learned that competition for students with liberal arts backgrounds is becoming more critical as the demand for personnel in the social work field increases. We are requesting an additional 20% increase in social work staff during the next biennium.

The general impression I gained from visiting colleges through Oregon, Washington, Idaho and Montana indicates a serious need for the expansion of the

undergraduate programs in the liberal arts field. The demand for the graduate-trained social worker is even more critical and expansion of the capacities of graduate schools in this area would be of tremendous help. The problem is certainly a lack of manpower in the field of social work, for both graduate-trained and undergraduate personnel. The demand for personnel far exceeds the supply in the field of social work; therefore, we wholeheartedly support any legislation that would contribute towards relieving this problem. We would agree that the expansion of the school programs and facilities in this area would be a major step in the right direction.

Pennsylvania.—Under legislation adopted in 1961, the Pennsylvania Department of Public Welfare has financially assisted 352 persons to complete graduate education in this field. Each is committed to employment by the Department or a county after graduation. However, there are today several hundred vacancies in this Department for persons with the Master of Social Work degree. Private agencies and county welfare programs in Pennsylvania also need hundreds of trained social workers . . . They are in desperate short supply.

In our child welfare, mental health, mental retardation and public assistance programs alone, we could immediately employ hundreds of trained college graduates. Those who have taken an undergraduate major in social work are especially valuable to us, but only a handful of the many colleges in Pennsylvania offer this major. This measure would assist the graduate schools to expand the number of students they can accept and would, we believe, stimulate undergraduate schools to establish a curriculum for whose graduates there is great demand.

Puerto Rico.—In the light of our present staff situation and our needs for qualified personnel in our public welfare programs, we endorse strongly this bill. Our staff shortage reached this last year its critical point when vacancies in social work positions amounted to more than 30 percent. Within social work positions assigned to direct services, our rate of vacancies rose up to 50 percent. This situation has been limiting so much the development of our public welfare program, especially our Child Welfare program, that we have been forced to increase our use of untrained staff for this program. The trend has shown that year after year the child welfare program has been depending more and more on college graduates for the rendering of direct services to child welfare cases irrespective of the nature and complexity of situations coming to our attention. As of now, the number of untrained positions far outnumber the partially trained staff in direct services. We anticipate that this situation will imply a difficulty for us to reach the goal that the Children's Bureau has set for 1975, in relation to the availability of trained staff for child welfare services. Our Bureau of the Budget does not even consider the assignment of additional social work positions as long as our rate of vacancies in the existing positions continues to be so high. On the other hand, the possibility of having some trained or partially trained staff for direct services in our public assistance program will have to be delayed for years as long as the present limitations in the availability of social work manpower continues to be a problem. The number of our supervisory staff at the district level with only partial training in social work also outnumber those who are already fully trained.

One of the most limiting factors which influence the above mentioned situation is the fact that we have only one school of Social Work in Puerto Rico. The enrollment of students entering this school is very small as compared with our needs in Public Welfare, not counting the needs of other public and private agencies in need of social work staff. During these last two years we have appropriated some funds to the School of Social Work so that they may engage in an accelerated plan of studies for a first year training in Social Work. We do not know whether within our present fiscal limitations we can go on with the above mentioned plan during the next few years. The University of Puerto Rico, because of inadequate appropriations has been unable to expand its training program. Therefore, we feel that if the Social Work Manpower Training Bill gets approved during this session this would mean a great help not only in getting an expansion of our graduate school, but also in the development of an undergraduate School which the University of Puerto Rico has not been able to develop up to now.

Furthermore, we have made special efforts near the Catholic University, one of our private universities in the southern part of the island to interest them in the development of a graduate program. The University administration is already motivated toward the establishment of a graduate school, and so far

meetings have been held with representatives of the Council of Social Work Education. The question of availability of funds has been delaying the start of such a program.

We anticipate that if federal grants are made available for the development and expansion of schools, another of our private universities (Interamerican University), at the Western part of the island would consider favorably the possibility of the organization of another School of Social Work, as well as the initiation of undergraduate training.

Tennessee.—The Department is experiencing a great deal of difficulty in recruiting, training, and retaining qualified staff in administrative and supervisory level positions. Graduate training in a school of social work is a requirement for most of these positions. Presently, we have a total of 17 vacancies in our field offices. In the fiscal year 1966-67, we will be sending 42 staff members to graduate schools of social work and, with few exceptions, this group will be returning to administrative or supervisory level positions. However, practically all of this group will be needed to fill vacancies resulting from resignations, supervisory requirements as the result of the expansion of casework staff, initiation of new programs and services, demonstration projects, and retirement.

Based upon our experience in the past few years, the Department cannot depend entirely on our professional educational leave program to satisfy our requirements for qualified administrative and supervisory personnel. Other sources must be developed. The social work manpower program would be an important beginning step toward the development of other sources. Graduate schools of social work certainly need to be expanded and improved.

Washington.—Our needs for qualified personnel are rather great and it is doubtful that the existing graduate schools will be able to fill this need. As you are no doubt aware, a great many of our B.A. level positions are established at this level simply because we are unable to attract and retain persons to fill these positions who do have the full professional training. In this state we do not have too much difficulty recruiting at the Bachelor's degree level; however, there is a real shortage of pre-social work undergraduate majors. Because of this, we feel that (this) legislation would be most helpful to this as well as other social service agencies.

West Virginia.—As of this date, in order to reduce our caseload to sixty cases per worker and to reduce the supervisory load to five workers per supervisor, we need approximately 300 college graduates and some eighty persons with graduate work in social work. * * * I see no possibility of recruiting the number of persons needed for supervisory positions within the next three years.

At the request of this Department and the School of Social Work at West Virginia University, our Governor is calling a meeting of representatives of all undergraduate schools in the State to attempt to have them include either courses leading to an undergraduate degree or a social work sequence in their undergraduate curriculum. I have considerable question as to whether legislation in question will be helpful.

* * * I would much rather see existing schools strengthened than to see expansion that would result in a greater number of poorly trained students being turned out by the various schools.

Wisconsin.—All of our services concur in the opinion that there is ample evidence that for a goodly number of years in the future, demand for trained social workers, in terms of those with a master's degree in social work, will far exceed the supply. Graduate schools of social work have been unable to keep up with the increasing demands for social workers, and it appears that they will not be able to do so in the near future.

The Social Work Manpower Amendment appears to recognize an urgent overall need for increase of social work manpower. This is true in whatever field of specialization we direct our observations.

In the field of public assistance our current vacancy announcement for county welfare departments lists over 50 positions requiring a master's degree in social work, and with the extension and improvement of the quality of services concept in public assistance in the years ahead, the likelihood for further increase in the need for trained social workers is not difficult to foresee.

In the field of child welfare the need for trained workers has been projected on the basis of future caseloads. Even with the projection that only half of child welfare workers would be required to possess a master's degree in social work, a very substantial increase in provision for training of workers is readily foreseeable.

It could be observed that the Department is not presently encountering much difficulty in enrolling stipend students in recognized schools of social work, but unless those schools expand their facilities in keeping with growing demand, greater difficulty should be foreseen within the very near future.

There is also some feeling that the proposed appropriation of \$750,000 for 1967 and \$1,250,000 for 1968 for the entire country will not finance much of an expansion of undergraduate and graduate school training program.

This proposal strikes us as being a step in the right direction. It provides some recognition of the problem and, if enacted, would hopefully provide experience with such a program that would lead to more nearly adequate provisions in the future.

The CHAIRMAN. Are there any questions of Mr. Schmidt?

Mr. BURKE. Mr. Chairman.

The CHAIRMAN. Mr. Burke.

Mr. BURKE. I just wish to thank Mr. Schmidt for his contribution and his recommendations on the child welfare problem, and we hope we are going to be successful in getting a major part of that bill into this bill here this morning.

Mr. SCHMIDT. Thank you, sir.

The CHAIRMAN. Mr. Schmidt, you have been a very fine witness. We appreciate your being with us. If there are no further questions we thank you, sir.

Mr. SCHMIDT. Thank you.

The CHAIRMAN. Mrs. Mendelson, if you will have a seat and identify yourself for the record by giving us your name, address, and capacity in which you appear we will be pleased to recognize you.

STATEMENT OF MRS. MARY ADELAIDE MENDELSON, ASSOCIATE EXECUTIVE SECRETARY, WELFARE FEDERATION OF CLEVELAND; ACCOMPANIED BY RICHARD E. STREETER, COUNSEL

Mrs. MENDELSON. Yes. I am Mary Adelaide Mendelson. I am associate executive secretary from the Cleveland Welfare Federation of Ohio.

The CHAIRMAN. We are pleased to have you with us and you are recognized. If you omit any parts of your prepared statement, do so with the knowledge that your statement and the material appended to it will be included in the record, without objection.

Mrs. MENDELSON. Thank you. I am speaking neither for nor against H.R. 5710 in its present form. Rather, I have accepted this opportunity to speak on the issue of whether H.R. 5710 ought to be revised to deal directly and explicitly with certain problems of nursing home care; and it is my conviction, for reasons which will be explained shortly, that a revision must be made in order to protect the financial interest of the Federal Government and the human interest in decent care for nursing home patients.

Present with me today is Richard E. Streeter, who is counsel for the Cleveland Welfare Federation. The federation is a nonprofit organization which assists in the planning and coordination of private and public health and welfare efforts in Greater Cleveland. Approximately 2½ years ago I was employed by the federation to work in the area of improving nursing home standards and practices.

During the course of this assignment, a detailed study was undertaken of nursing home care. The report which has been assembled, of

which this is a copy, has been placed in the hands of the chief counsel for this committee. Because the report details factual practices of specific nursing homes, we desire to maintain the confidentiality of its contents. But we would be pleased to discuss it at greater length in executive session should the committee deem this appropriate or desirable.

We would like to point out that the GAO has undertaken a study and will issue its report shortly which we understand will verify the existence of some of the practices detailed in our report. (See p. 873.)

NECESSITY FOR ATTENTION BY HOUSE WAYS AND MEANS COMMITTEE TO
NURSING HOME REVISIONS IN H.R. 5710

Our work in the nursing home field has led us to the conviction that there is a genuine need for this committee to be informed about and alerted to the real facts and issues in the field of nursing home care.

The specific Federal financial interest is in medicare, the health program under title XIX, old age assistance programs under title I and veterans financing programs.

Enormous sums are being spent through these programs on patients in skilled nursing homes. There is, we believe, serious doubt whether you, the Federal Government, are in fact purchasing the kind and quality of care you think you are purchasing.

You are entitled to ask, for example, whether some of the physicians' services you are purchasing have in fact been furnished; we believe not.

You are entitled to ask whether some of the pharmacies you support financially have actually supplied necessary and proper medications for which they were paid; we believe not.

You are entitled to ask whether Federal vendor payments in the amount of at least \$212 million annually are buying either the quality of care you have a right to expect or, in some instances, even the care itself; we believe not.

We are prepared to substantiate our convictions and to offer to the committee suggestions for amendments to protect Federal interest and the nursing home patients.

First, however, it would be well if the committee were to understand fully the nature of the nursing homes we are discussing and the patients who are being served by them.

DESCRIPTION OF SKILLED NURSING HOMES AND THEIR PATIENT POPULATION

There is a surprising lack of real understanding of the skilled nursing home business. When I speak of skilled nursing homes, I am talking about homes which advertise and provide what is known as skilled nursing care.

Most, and I mean almost 100 percent, of the patients are over 65 and probably over 70. One-half to 60 percent receive old-age assistance benefits. In the Cleveland area, 53 percent of the public welfare patients have no family. Even where there are relatives, the patient frequently does not see them. These patients are, in other words, alone.

This fact is important because there is no one interested in protecting or defending most patients. Their stay at the skilled nursing

home will average between 2 and 3 years, and it terminates with death. They are not rehabilitated; they do not return to the community; and, as I understand it, medical science today does not know how to rehabilitate them.

Some people refer to these patients as needing "custodial care" meaning just general supervision. It is a fact, however, that large numbers of these patients are on prescription medications; they need help with bathing, dressing and walking, all of which require some skill in handling; and in general they are sick but not so acutely as to be hospitalized.

Contrary to popular belief, many of these people go into a skilled nursing home from their own home—or at least not from a hospital—and are placed there in approximately one-half of the cases by the old-age assistance caseworker.

This caseworker is required by law to be more concerned with the financial needs of the patient than with the individual's total welfare. And under prevailing law and existing practice the worker will not see the patient for another year at the very best.

The nursing homes which I am reluctantly describing will have both private and welfare patients. They will have patients requiring intensive care and patients needing only some supervision.

In fact, many of the younger ones or those under 65 are really only alcoholics, but the community has no better plan for them than confinement in a skilled nursing home.

Some of these nursing homes, although not a large number, have already been certified as extended care facilities. In other words, the extended care facility and the skilled nursing home may be the same place, and the patients constitute a mix—a mix both physically and financially.

UNBELIEVABLY POOR CARE BEING PURCHASED BY FEDERAL FUNDS

This then is the setting. The care furnished is often unbelievably poor. There are many examples but suffice it to relate one story only.

A State inspector reported finding that a particular home, having served a light supper at 4 p.m. made no provision for breakfast for its 40 patients, approximately 20 of whom were bedfast, and almost all of whom were public assistance recipients. Your money paid for these unserved meals; and there is evidence that such poor care is all too commonplace.

LOW PUBLIC ASSISTANCE RATES AND MINIMAL STATE REGULATION ARE NOT RESPONSIBLE FOR POOR CARE

It is a common belief, once shared by the Welfare Federation, that deplorable conditions in many nursing homes were due primarily to two factors:

1. Low public assistance rates paid for the care of the many welfare patients;
2. Minimal licensing regulations on the part of State governments.

We now know from our extensive study of nursing home conditions that these premises are in error—that poor care will not necessarily disappear if assistance rates are higher; and the conditions persist in spite of regulations which are hardly minimal—in fact the regulations in

Ohio and some other States do not differ measurably from the medicare conditions for participation.

It is necessary to point out, moreover, that some homes provide good care in spite of the many difficulties inherent in performing well. As for the preponderance of homes with the largest number of patients, their operators are not doing a good job.

In fact, Mr. Chairman and members of the committee, they are not only doing a poor job but they are, to some extent, defrauding the Government by not delivering the service for which you are paying.

What then are some of the factual areas where inquiry by this committee seems warranted?

PHENOMENON OF MULTIFLYING BEDS IN SPITE OF LOW RATES

One subject of interest is the phenomenon of the multiplying of skilled nursing home beds in spite of the large number of welfare patients and attendant low rates. In the Cleveland area, as of January 1966, in a 4-year period only nine homes out of 86 had closed, 13 new homes had opened, and one-half of the 50 homes with whom I have had contact have expanded or plan to expand.

I suggest that a proprietary business does not remain in business if it is losing money. Who, one wonders, is financing these homes? The Senate Subcommittee on Long-Term Care found examples of some questionable financing deals involving high interest rates. Indeed, the hearings and other reports which the Senate subcommittee has would provide data that should be most useful to anyone conscious of and concerned about the amount of public money spent for skilled nursing care.

RATES AND COSTS

It should be mentioned that even some homes concentrating almost 100 percent on welfare patients are expanding in spite of what is considered impossibly low rates. Several nursing home operators—two of whose facilities are now certified extended care facilities—gave me quite revealing stories on their costs—and quite a different story from the usual one. Two claimed their costs, including payments on the mortgage were below \$200 a month per patient; and one—a new facility—claimed costs were below \$300 a month.

As extended care facilities, they will be getting most likely in the neighborhood of \$540 a month from medicare. Under title XIX under the Ohio plan, they will be getting \$300 a month. Private patients would have paid in these homes a few months ago between \$225 and \$300 a month. It is doubtful if you would find that additional services have been added that would justify an additional \$240 a month.

Incidentally, I am not trying to justify low rates. I am merely suggesting that the Congress should know that low rates have not closed homes. I would hope that the Congress would also agree with me that high rates do not insure good care.

PHYSICIANS

Our study also revealed that some physicians who were billing the State for two visits a month for old-age assistance patients in the nursing homes were not always seeing these patients two times a month.

Bills rendered were for services not provided. In fact, one of the problems that we frequently hear decried is the difficulty of getting medical care for private patients in skilled nursing homes.

Such, however, does not seem to be the case with public assistance patients, many of whom were presumably seen more times than the State licensing regulations required or the physical health of the patient necessitated—at least bills to the State would so indicate.

Was the care actually provided? If it was, why are these patients frequently reported by the hospitals or the morgue as being emaciated, covered with bed sores, and physically neglected? Yet not once has a physician in my county called the Aid for Aged office to complain about the care provided by the home later criticized by other authorities.

As a further example of possible fraud, I am reminded of payments made under the medical assistance program to a doctor for alleged medical care furnished a number of patients. This “physician” however, is neither listed in the telephone directories as a physician nor registered with the Academy of Medicine.

DRUGS

Another curious fact, found in some instances, was that drugstores were being paid for “furnishing” more drugs than the patients, or the nurses, or the nurses’ records indicate were received.

To what extent this is prevalent, I am in no position to say. However, it is a fact that one drugstore in my community annually does a \$170,000 business on old age assistance drugs alone. There is no reason, in my judgment to assume that these medications were all actually delivered, and if delivered, used, and if used, needed. Indeed, one nursing home administrator has claimed that his particular home, as well as others, normally obtains his household supplies under the guise of drugs for patients, paid for as drugs by old age assistance. Another nursing home operator explained to me, and to the veterans hospital social worker, that his drugstore had billed a private patient three times in 1 month, to the amount of around \$60, without ever itemizing the bill. The patient disclaimed having received that amount of medicine.

One pharmacist has admitted that several nursing homes offered percentage kickbacks if he would service their telephone accounts. It was made clear that if the prescription is not for an unreasonable quantity, there would be no check by the authorities; and there was no way of knowing that the patient allegedly receiving the drugs either sees them or needs them.

There are many other opportunities for supplementing nursing home “income” through drug payments. For example, one of my informers has advised that a drugstore in my county popular with nursing homes is owned in substantial part by a nursing home operator managing a large number of beds.

ADDITIONAL FIELDS OF INTEREST

There are still other areas requiring inquiry: lab work that may not be needed, but is paid for by public funds; podiatrists—with a frequency not generally countenanced in well-run homes—providing

quick and routine toenail care, paid for by title XIX; payments received for orthopedic shoes when the "patient" is seen wearing only slippers; and so on.

In fact, Mrs. Griffiths, you asked yesterday a question relating to the thefts in hospitals. This kind of theft goes on in nursing homes, but in a way I am speaking of what might be described as another kind of theft—personal expense money, for example, which patients are supposed to get but never receive, clothes which are stolen, billings for beauty salon work that is never done, or social security checks which aren't received.

SUGGESTED REVISIONS IN H.R. 5710

There are, of course, good nursing home operators whose service to the community needs support and recognition. In all too many instances, however, the abuses, of which the foregoing are a sample, are of such serious consequences, both financially and for the patients whose lives are involved, that H.R. 5710 should be revised to deal expressly with nursing home problems.

Because of time limitations, I request, Mr. Chairman, permission to incorporate our suggested revisions as an addendum to this hearing; and should the committee desire further detail from our study I would be glad to appear at an executive session if this would serve your purpose.

And permit me again to refer to the GAO report which should be completed in the near future.

Thank you for this opportunity to appear before the committee.

The CHAIRMAN. Thank you, Mrs. Mendelson. Mr. Curtis.

Mr. CURTIS. Is that GAO report a report on Ohio and Cleveland?

Mrs. MENDELSON. Yes. There is also, as I understand it, a report on California and I think there is something coming out on Massachusetts.

The CHAIRMAN. Thank you, Mrs. Mendelson, for bringing to us this information. You have an addendum to your statement.

Mrs. MENDELSON. Yes.

The CHAIRMAN. Do you want that included?

Mrs. MENDELSON. I didn't pause long enough. I do ask permission if that could be included.

The CHAIRMAN. Without objection that will also be included in the record and we appreciate your offering to come to us in the executive session of the committee.

(The addendum referred to follows:)

ADDENDUM TO STATEMENT BY MRS. MARY ADELAIDE MENDELSON OF THE WELFARE FEDERATION OF CLEVELAND

The conditions which I reported in my testimony have led the Nursing Home Committee of The Cleveland Welfare Federation to suggest some areas in which revisions of the Social Security law should be made. This addendum singles out those areas but does not attempt to develop precise amendments. The report referred to in the testimony provides the factual rational for proposed revisions.

TITLE XVIII, PART A

REIMBURSEMENT FOR REASONABLE COSTS SHOULD BE FOR CARE IN FACT PROVIDED

The Nursing Home Committee of the Welfare Federation recommends that the law provide a procedure under which reasonable costs for which reimbursement is made reflect services actually rendered. Even at this early date, there

are indications that services are not always actually furnished but are nonetheless paid for by reimbursement. Under the law, the costs of services are to be determined and a charge made on the basis of such determination. But the requirements of law can be avoided. For example, the cost of physical therapy can be figured and a charge made, but this does not insure that therapy is actually provided for the patient. No clear provision is made for an inspection of the quality of the care or a determination that care is, in fact, being provided. The law should provide for such inspection and determination.

UTILIZATION REVIEW PLAN

1. Definition of extended care should be refined

There is confusion regarding the kinds of patients who are eligible for extended care coverage. All that is necessary is that the patient be in need of care for the condition for which he was placed in the hospital and that this care be provided in a facility which, among other things, furnishes skilled nursing care. Many patients do need skilled nursing care for the condition for which they are hospitalized, but it is frequently long term care for many more days than the 100 days allowed under Medicare. The utilization review committee of both the hospital and the extended care facility have complied with the law when the patient is sent to and received at the extended care facility. Perhaps this is the purpose of Medicare, but if so, we fear that the patients will have 100 days of extended care and then move to a less expensive skilled nursing home for another year or two.

We think the patient should be saved from the unnecessary and traumatic moves from one facility to another. The patient will be spared when the definition of extended care is further refined so that the utilization review committees can perform their job.

2. Provision for a different kind of a utilization review committee

We further believe that a different kind of utilization review committee should be considered. Presently, in Ohio as elsewhere, a physician must determine the need for nursing home care. The physician may have a financial interest in the extended care facility and, therefore, be unable to render an impartial judgment. Title XVIII provides that there shall be two or more physicians on the utilization review committee. Many extended care facilities may accomplish this by combining their physicians on the committee. Such a committee would not ensure an objective review of admissions, duration of stays, or services furnished.

We have been told that even where a committee of physicians from outside the facility form a part of the utilization review committee, it is very difficult to oppose the house physician. We understand that the committee reviews the records but does not see the patient. We are concerned that the care may not actually be provided. If the patient is not seen, and, for that matter, if the institution is not seen, then the utilization review committee is handicapped, to say the least, in making its judgment. We would suggest, therefore, that one of two changes (or both) be made in the make-up of utilization review committees.

First, the law could require that there be a medical team on the state level, composed of a physician, a nurse, and a social worker, which will make a spot check on extended care facilities and the Medicare patients to determine the kind of care given in fact, the conditions of the facility, and the integrity of the utilization review committee's report. Second, the law could require that the hospital utilization review committee be used as the review committee for the extended care facility with which it has a transfer agreement. If this were done, it is possible that the hospitals would know better the kinds of patients who should go into an extended care facility. They would know what happens to the patients after discharge from the facility. They could follow the actual care of the patient, thus providing a continuity of care not realized under the present law.

INSPECTION SHOULD BE AT LEAST ANNUALLY

We recommend adoption of a provision requiring that the extended care facility be inspected at least annually. The Conditions for Participation allow a state to visit or resurvey institutions where necessary to ascertain continued compliance or to fit into the periodic or cyclical survey of the state programs. Our evidence indicates that homes must be inspected regularly. Information persists in coming to us, even regarding certified homes, that personnel, for example,

are added for purposes of the survey and not for the purpose of providing the services needed. A spot check by the medical team suggested for utilization review above would, of course, mean a continuous threat of inspection of both patient care and the facility which in turn would increase the chances that the homes will act in good faith. However, we believe the law should provide an additional check by making inspections mandatory. The Conditions for Participation allow some leeway in compliance. There should be substantial compliance with the standards, if not full compliance, and there can be conditional compliance. In those instances where there is not full compliance, the state is required to resurvey within a prescribed time. Leeway must, of course, be left so that homes making every effort to comply are given the time in which to do so. Based on our evidence, the fact remains, however, that unless there is mandatory inspection and some check on the resurveys by the Federal government there are homes that will continue to be certified, although not, in fact, complying.

OWNERSHIP SHOULD BE DISCLOSED

We question the qualifications of some nursing home owners. We recommend that the law requiring that the extended care facility have an effective governing body should be amended to require further that ownership be fully disclosed. It is of vital importance to know whether a facility is connected through ownership with groups who can have an interest detrimental to the best welfare of the patient.

FINANCING CHARGES SHOULD REFLECT PROPER INTEREST RATES

In light of evidence available of unduly high interest rates charged for mortgage loans, we would like to see that reasonable costs do not permit reimbursement for interest charges above those normal for the area at the time the loan was made.

TITLE XVIII, PART B

(The suggestions of the Cleveland Welfare Federation for amendment of Part B of Title XVIII are not related to the problems discussed in my testimony but are of great significance to nursing home patients.)

BILLING METHODS SHOULD BE CHANGED TO PROVIDE A THIRD CHOICE

Since many physicians bill the patient directly, rather than the carrier on assignment, and since the carrier can only pay if the bill is on assignment or prepaid, patients have been caught in a vise. The doctor who refuses assignment demands his pay. The patient must find the money, which he may only be able to do by withdrawing from his savings or by getting a loan. Either method can and does work a hardship on many patients. Therefore, we recommend a third method of reimbursement, namely, that the patient be permitted to turn his unpaid bill over to the carrier to process. The person over 65 may be easily confused. The simple method of turning over an unpaid bill to be handled for him has the merit of clarity.

PHYSICAL EXAMINATION IN SOME INSTANCES SHOULD BE COVERED

Routine physical examination is not covered by Medicare. But people in nursing homes for long term care present a special situation. Some state licensing regulations, as well as wise health care, require periodic examination by the physician. This should be covered explicitly under Medicare Part B.

TITLE XIX

COVERAGE—ADDITIONAL CARE SHOULD BE ADDED

Title XIX includes coverage of skilled nursing home care. No definition is provided for skilled nursing care. It is left to the State plan to determine who is eligible and how he becomes so. There is confusion, however. The confusion arises because there are three different kinds of care into which patients fall, all three of which are provided in the same kind of home: extended care, skilled care, and custodial care. Both extended care and skilled care are defined only through describing what the facility shall provide. Custodial care is excluded from coverage in extended care. Some people equate long term care with cus-

todial care. We think that custodial care should be defined. We believe it should be defined to mean personal assistance only. Medication is not a part of the treatment, and the assistance is actually a kind of supervision. These people can take care of themselves, but they might forget to eat, or they might get lost, or they might forget what happened the day before. They need some protection but they do not need the skills involved in bathing, feeding, etc. They may need the protective environment for a long time. Most of the people in skilled nursing homes are also there for a long time. They, however, need more care than personal assistance. We believe that there would be less confusion if the Federal government matched funds for custodial care, although we recognize that it is not medical care. Perhaps in so doing, the other programs of extended care and skilled nursing care would be easier to administer and less likely to be abused.

REASONABLE COSTS FOR NURSING SERVICES SHOULD BE REIMBURSED

Reasonable costs should be paid for skilled nursing care. The necessary studies apparently have not been made to determine what services are needed or what the costs would be. For example, equipment for physical therapy is expensive. The equipment may not be necessary for long term care patients who, nevertheless, need skilled nursing care. Such equipment may, on the other hand, be necessary for extended care patients who presumably can be rehabilitated. The services provided under title XIX in skilled nursing homes should be only those necessary for the comfort and maintenance of the patient. The reasonable costs should be reimbursed, excluding questionably high interest rates. We cannot expect necessary services or demand reasonable standards unless we agree to pay the fair cost.

FEDERAL STANDARDS SHOULD BE ESTABLISHED

Since most patients need long term skilled nursing care and since 50 or 60% of the patients in the skilled nursing homes receive public assistance, attention must be given to maintaining standards in these nursing homes as well as in extended care facilities. These standards should include provision for a medical team which can check the necessity of the care provided and the fact that care was, in fact, provided. In addition, certain minimal standards relating to nursing staff and medical consultation should be ensured. Some provision for diversional activities might be included, particularly if reimbursement is based on a reasonable cost.

REPRESENTATIVE PAYEE

We recognize that this subject is not a part of Titles XVIII or XIX but we would like to make a comment as a result of our findings. Social Security provides a method whereby a person incapable of handling his own check can be protected through the designation of a representative payee. We understand that a General Accounting Office report has been made which includes evidence of misuse of this procedure. We have found that some nursing home operators have been named representative payees and have abused their responsibility. We do not know that specific corrective measures should be provided, but we feel strongly that some protection should be offered the old and often confused patient who in some instances has been deprived of his Social Security benefits.

The CHAIRMAN. Off the record.

(There was discussion off the record.)

The CHAIRMAN. Are there any questions of Mrs. Mendelson?

Mrs. GRIFFITHS. I don't have any questions, but I would like to say that I think she has made more suggestions for saving money than anybody else has made so far. I certainly appreciate hearing you. In my opinion we should have had a full house.

The CHAIRMAN. Mr. Byrnes.

Mr. BYRNES. I share the view that this information and the charges made are more than innuendos; they require an investigation by this committee.

Let me ask this: Under public welfare in Ohio, are these particular recipients certified and admitted by the State? Doesn't the county perform administrative functions in conjunction with this process?

In Wisconsin we operate through the county—with county sharing in the costs—then the State, and then Federal. The administration is for the most part local.

Mrs. MENDELSON. There are several things I think should be pointed out with regard to that. First, the homes themselves as the nursing homes, are licensed by the State health department.

Now, some parts of county and city are used in that process in Ohio such as the building department, and so on.

Mr. BYRNES. No, I am referring to the authority that is responsible for certifying a patient and making the arrangements for their admittance to the nursing home.

Mrs. MENDELSON. This is done on the county level by what we call the aid for aged office. This presently is administered by the county itself, but it is under the supervision of the State.

However, each county has its welfare department.

Mr. BYRNES. Then you operate very much like Wisconsin, which brings me to the basic question. Although the Federal Government bears a large share of the cost for these services, I assume the county and the State also share in these costs.

Mrs. MENDELSON. I believe, Mr. Byrnes, that this has changed or will change in Ohio. You see, the reason I can't answer you directly is that we have just gone under a reorganization of our welfare system. However, as I understand, the aid for aged program is financed by the State and the Federal Government, not the county.

Mr. BYRNES. No county participation?

Mrs. MENDELSON. That is right, no county participation. That, however, may change in the future and it will change according to the county's population, ability, and so forth, but I am not clear on that point, Mr. Byrnes.

Mr. BYRNES. Where this occurs at the county level and the county is participating, I can't understand why examples from your investigation haven't been brought to the attention of the local prosecuting authorities.

In all of these cases the State is participating in the costs. If services or drugs are billed to the State which have not been rendered, if there is a kickback on drugs, or if food was purchased but not delivered, the State is being defrauded. I can't understand why the State's attorney has not acted to protect the State's funds.

That doesn't excuse the Federal Government from its responsibility of overseeing the proper expenditure of Federal funds. But if your examples are actual cases, there has been a great failure of State and local law enforcement.

Mrs. MENDELSON. Mr. Byrnes, let me first point out that the Welfare Federation is not an investigatory body. We haven't any authority—

Mr. BYRNES. You have these cases. There are the results of your investigation.

Mrs. MENDELSON. Things that we have dug up. I just wanted to put that on the record, because we don't have the resources to go to

the extreme which you are suggesting. Of course, as a result of what we did find we felt it necessary to come here to Congress. We have talked to some extent on the other issues with State authorities.

One of the things I think that is extremely difficult to appreciate is the complication of the way in which billings are done, for example, so that it is almost impossible, without someone really going in, to know, Mr. Byrnes, whether, for example, a drugstore is delivering the merchandise.

Mr. BYRNES. The State and local authorities have the ability. I understand that you don't have the power of subpoena or the funds and personnel to do a thorough investigative job, but you have made some very serious charges. Do you bring the same information that is contained in your statement, plus the more detailed information you suggest you can provide in executive session, to the attention of any State law enforcing authority or State welfare department? Is this the only place you have brought this information.

Mrs. MENDELSON. This is the only place we have brought it.

Mr. BYRNES. Why?

Mrs. MENDELSON. Because we have felt that this is a national problem. The Senate subcommittee, for instance, has had hearings. You will find that this situation exists elsewhere.

Mr. BYRNES. But the basic administration of these programs is at the State and local level. I think you are talking primarily about old-age assistance cases. They are put in nursing homes for custodial care instead of paying for their rent or their shelter.

They have a contract with the home. But under the law the basic administration of these programs is with the State. I would assume in the position that you are in that you would be acquainted with where the basic responsibilities for administration lie.

Again I repeat, I am not suggesting that the Congress or the Federal Government should turn its back on this. We shouldn't. But those with fundamental responsibility should have an opportunity to act, and should not simply be bypassed.

Mrs. MENDELSON. Mr. Byrnes, may I go back to the history of this and how it developed, and explain what our reasoning was?

When we realized these findings we debated where we should go with them. Now, at that time, or really shortly after the Fitchville Nursing Home fire that took place in Ohio, the welfare federation hired me. At that time there were hearings which were starting throughout the country by the Senate Subcommittee on Aging. This was already organized. We knew this or suspected that this is a national problem. We knew that there was body of information that was already being gathered.

We therefore came to the Senate subcommittee with our findings. Again let me emphasize, realizing that in our opinion this was national, realizing that already—

Mr. BYRNES. But law enforcement of this kind is not exclusively national. The State is the administrative authority for determining that State money is being properly spent. The States certify to the Federal Government that they have properly and honestly paid money for covered services and that they are entitled to share their costs with the Federal Government.

Mr. BURKE. Would the gentleman yield?

The CHAIRMAN. Pardon me. I think it would be fair for us to inquire as to whether Mrs. Mendelson, first, is a lawyer. Are you a lawyer?

Mrs. MENDELSON. No, I am not.

The CHAIRMAN. Well, now, I don't believe we should attribute all these fair ladies of the land with a complete knowledge of the law, and I am sure Mr. Byrnes doesn't.

His point is this, as I understand it: That this is at least a joint responsibility. I would be amazed to learn that any of this is going on in my own State and I think Mr. Byrnes perhaps shares that thought with respect to the State of Wisconsin.

At least I have heard of none of it and I think that in the position I am in I would have heard of some of it if anybody knew anything about it. Certainly if it were existent in every State I would think then that you would want to come to us about it, but since there is a possibility that this is only existent in some States I would think that there is a State responsibility as well as a responsibility on our part to see that corrections are made.

Let me ask a question if I may about your Ohio situation. Is there an agency at the State level that determines standards with respect to nursing homes within Ohio?

Mrs. MENDELSON. Yes.

The CHAIRMAN. Does that agency have anything to do with the type of people who may own nursing homes, who they are? Does it grant licenses?

Mrs. MENDELSON. Yes. We must disclose who the owners are and the owners must be reputable.

The CHAIRMAN. Do you know of any ownership of any nursing homes in your area by people of dubious reputation?

Mrs. MENDELSON. Yes.

The CHAIRMAN. It seems to me that somewhere along the line a little bit of tight supervision and control has fallen down. I think that is Mr. Byrnes' point. So we certainly will have you back with us. I understand that you have been more or less the public advocate in this matter of trying to look after the interests of those who do not have anyone else doing it, and you are to be commended for that spirit and that attitude. These are very serious charges that you make. We certainly want you in executive session to give us further information.

If there is any way that we can prevent a continuation of this situation I know that the committee would be unanimous in its feeling that we want to do that. I think it will require some action at State level also in the policing of whatever we do to see to it that Federal provisions in this respect are carried out. We can't do that ourselves. Our main concern is with how we can act and be certain that we actually get the result we want in the field. Mr. Vanik.

Mr. VANIK. Mr. Chairman, I just want to point out that the welfare federation, through the work of Mrs. Mendelson, has done something that needs doing all over the country. She has gone into the individual homes and looked into the plight of the people that are confined. I doubt that we know as much as we should about these matters because no one is doing the public's work and really checking the plight of the people.

The welfare federation was also the subject of testimony that was given earlier today in the statement by Mr. Morris, representing the American Nursing Home Association, in which he directed attention to the Cleveland plan which was evolved through the welfare federation in determining need, and amortization, and depreciation of nursing homes and hospitals.

I just want to pay some tribute to the work of the welfare federation and to the leadership of our Cleveland community in trying to develop a real social responsibility for the plight of our people.

Mrs. MENDELSON. Thank you, Mr. Vanik.

The CHAIRMAN. We do appreciate your coming to the committee and we commend you for the efforts that you have made to try to protect these people who are in these nursing homes.

We thank you.

(There follows a report to the Subcommittee on Long-Term Care, Special Committee on Aging, U.S. Senate, on an inquiry into alleged improper practices in providing nursing home care, medical services, and prescribed drugs to old-age assistance recipients in the Cleveland, Ohio, area made by the Comptroller General of the United States, March 1967:)

**REPORT TO
SUBCOMMITTEE ON LONG-TERM CARE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE**

**INQUIRY INTO
ALLEGED IMPROPER PRACTICES IN PROVIDING
NURSING HOME CARE, MEDICAL SERVICES, AND
PRESCRIBED DRUGS TO OLD-AGE ASSISTANCE RECIPIENTS
IN THE CLEVELAND, OHIO, AREA**

**WELFARE ADMINISTRATION
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE**



**BY
THE COMPTROLLER GENERAL
OF THE UNITED STATES**

MARCH 1967



COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D. C. 20548

B-114836

MAR 31 1967

Dear Mr. Chairman:

In response to your request dated September 20, 1966, the General Accounting Office has made a preliminary inquiry into certain allegations of improper practices in providing nursing home care, medical services, and prescribed drugs for old-age assistance recipients in the Cleveland, Ohio, area.

In accordance with your request, our inquiry was directed to a review of the policies and procedures of the cognizant Federal, State, and county agencies, which were pertinent to the activities discussed in a confidential report furnished to your Subcommittee, and a review of such information in the records of these agencies as we considered useful in assessing the desirability of undertaking a thorough investigation into the activities discussed in the confidential report.

The allegations which were the subject of our inquiry relate principally to the adequacy of enforcement of the State of Ohio nursing home licensing requirements for the standards of treatment and care of nursing home residents, the appropriateness of procedures and practices employed in placing welfare recipients in nursing homes, and the adequacy of State controls over payments to vendors, including medical or health care practitioners, and pharmacies.

Although certain allegations were made which related to the sources of financing for nursing home operations and the possible business, political, or criminal connections of nursing home operators, in general inquiry into these allegations was beyond the scope of our examination.

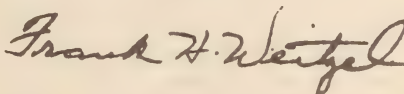
We did not visit or review the records of any nursing homes, medical or health care practitioners, or vendors of drugs and other medical supplies. Also, although we interviewed Federal, State, and county officials and personnel, as deemed necessary, to secure information and clarification of certain policies and procedures and their application, in accordance with the agreement with the staff of the Subcommittee, we did not apprise these officials of the bases for or the results of our inquiry or obtain their comments on our findings.

B-114836

On the basis of information obtained in our inquiry and described in the accompanying report, it is our opinion that, because of inadequacies in pertinent policies, procedures, and controls, or in their implementation, practices or deficiencies of the types described in those allegations which provided the bases for our inquiry could exist without detection by appropriate authorities or, if detected, could continue without appropriate corrective action. Therefore, we believe that each of the areas to which we directed our inquiry would warrant further examination or investigation, and in greater depth, to ascertain the extent to which the alleged practices or deficiencies do, in fact, exist and to develop suggestions for needed improvements in related policies, procedures, and controls.

We plan to make no further distribution of this report unless copies are specifically requested, and then copies will be distributed only after your approval has been obtained.

Sincerely yours,



~~Assistant~~ Comptroller General
of the United States

The Honorable Frank E. Moss, Chairman
Subcommittee on Long-Term Care
Special Committee on Aging
United States Senate

C o n t e n t s

	<u>Page</u>
BACKGROUND	1
ALLEGATIONS AND SCOPE OF INQUIRY	6
FINDINGS	8
Enforcement of regulations governing operations of nursing homes	10
Procedures for placement of aid for the aged recipients in nursing homes and determination of need for various levels of care provided recipients	26
Controls over payments to practitioners for services provided to aid for the aged recipients	35
Controls over payments for drugs provided to aid for the aged recipients	48
APPENDIX	
Letter dated September 20, 1966, to the Comptroller General of the United States from the Chairman of the Subcommittee on Long-term Care, Special Com- mittee on Aging, United States Senate	59

REPORT ON
INQUIRY INTO
ALLEGED IMPROPER PRACTICES IN PROVIDING
NURSING HOME CARE, MEDICAL SERVICES, AND
PRESCRIBED DRUGS TO OLD-AGE ASSISTANCE RECIPIENTS
IN THE CLEVELAND, OHIO, AREA
WELFARE ADMINISTRATION
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Pursuant to a request from the Chairman of the Subcommittee on Long-Term Care, Special Committee on Aging, United States Senate, the General Accounting Office has made a preliminary inquiry into certain allegations of improper practices in providing nursing home care, medical services, and prescribed drugs for old-age assistance recipients in the Cleveland, Ohio, area. A copy of the letter to the Comptroller General from the Chairman of the Subcommittee on Long-Term Care, requesting that the preliminary inquiry be undertaken, is included as an appendix to this report.

BACKGROUND

Under the Social Security Act, as amended (42 U.S.C. 301), the Department of Health, Education, and Welfare (HEW) is authorized to make payments to States in aid of programs administered under State plans, approved by HEW, for public assistance, including medical assistance to certain categories of needy persons.

The programs for which Federal aid is authorized by the Social Security Act and which are in effect in Ohio include, among others, the old-age assistance (OAA) program authorized by title I of the act and, since July 1, 1966, the medical assistance program authorized by title XIX of the act. Title XIX, which became effective January 1, 1966, authorizes Federal participation in the cost of

providing medical assistance to individuals who are recipients of assistance payments under programs authorized by title I and certain other titles of the Social Security Act. If provided for in the approved State plan, the cost of furnishing medical assistance to persons who need assistance for medical care, and who would be eligible for assistance payments under the other programs but for their level of income or other financial resources, is subject to Federal participation also, under title XIX.

HEW provides Federal financial participation in the costs incurred by the States in carrying out their respective welfare programs, in accordance with formulas established under the act. Funds are made available to each State on the basis of the State's estimated needs, subject to later adjustments based on actual cost experience.

Under the act, the States have primary responsibility for initiating and administering public assistance programs. The nature and scope of the programs are contained in State plans which, after approval by HEW, serve as the basis for Federal grants to the States. Under these approved State plans and related HEW administrative requirements, the States are expected to administer the public assistance programs in a proper and efficient manner and to ensure that expenditures subject to Federal participation are proper and are supported by adequate records.

HEW is responsible for assuring itself, through appropriate administrative reviews and audits of State program activities, of the adequacy of State program administration. Continuing reviews of State and local administration of public assistance programs are provided for in the Department's regulations (45 CFR 201.6). The purpose of these reviews is to determine whether the State agencies adhere to the Federal requirements, including the provisions of State plans.

HEW's nine regional offices provide general administrative direction and coordination of the federally aided State public assistance programs. The State of Ohio is included in Region V which is headquartered in Chicago, Illinois. Administrative reviews of State welfare program activities are primarily the responsibility of regional representatives of the Bureau of Family Services, Welfare Administration. Departmental audit activities are the responsibility of the HEW Audit Agency and are carried out under the immediate direction of regional auditors located in the regional offices.

The Ohio State plan, as approved by the Welfare Administration, provides for administration of the OAA program (in Ohio known as the aid for the aged or AFA program) by the local welfare agencies in each of the State's 88 counties. The Ohio Department of Public Welfare is designated as the single State agency with authority to supervise administration of the AFA program.

Prior to July 1, 1966, medical assistance furnished to AFA recipients was provided under the State's old-age assistance program with Federal financial participation under title I of the Social Security Act.

Under this program, the State plan provided for assistance payments to recipients in amounts necessary to cover their budgeted nonmedical needs after giving consideration to each individual's other income and financial resources. For AFA recipients who, because of their physical or mental condition, needed care in a skilled nursing home or rest home, the State considered the cost of such care, at rates or allowances established by the State, in establishing the budgeted needs of each individual as a basis for determining the amount of the required money assistance payment. The recipient utilized the assistance payment from the State, together

with his other resources if any, to make payment to the nursing home or rest home operator.

In addition, the State made payment directly to vendors of medical services and supplies, including physicians, hospitals, and pharmacies, for the medical needs of the AFA recipients.

Since July 1, 1966, payments to vendors of medical services and supplies needed by AFA recipients have been provided for under the State's title XIX medical assistance program. Also, limited nursing home care is provided under this program through payments made directly to the providers of the care. In general, however, the cost of skilled nursing home care required by AFA recipients continues to be covered, as previously, through money assistance payments to the individual recipients.

In November 1966, there were about 5,941 beds in about 85 nursing homes located in Cuyahoga County, of which 23 were being operated by nonprofit charitable organizations, 61 were being operated by private individuals or institutions for profit, and 1 was being operated by the county. As of January 1967, there were 1,684 AFA recipients receiving nursing care in these homes.

Money payments amounting to \$5.6 million were made in July 1966 to the AFA recipients in the State of Ohio. About 63 percent, or \$3.6 million of this amount, represented Federal funds.

The State Department of Health (SDH) of Ohio has responsibility for the licensing of nursing homes and for the enforcement of the provisions of the Ohio Revised Code and the rules and regulations issued pursuant thereto pertaining to the physical plant and equipment; nursing and other personnel serving the patients; sanitation; handling, preparation, and storage of food; treatment and care of patients; and recordation of and authorization for the administration of medications and treatment of patients.

The SDH is required to inspect each nursing home at least once each calendar year. Nurses and sanitarians assigned to district offices of the SDH perform health care and sanitary inspections. The building and fire departments of 14 municipalities in Cuyahoga County perform inspections of homes within their boundaries to determine the degree of compliance with minimum standards of the Ohio Building Code and local ordinances. Similar inspections of homes in rural areas are performed by the Ohio Department of Industrial Relations or by the State Fire Marshal. Reports of inspections are sent to the Nursing Home Unit, SDH, and a copy of each report is given to the operator of the nursing home.

ALLEGATIONS AND SCOPE OF INQUIRY

The allegations which were the subject of our inquiry relate principally to:

1. The adequacy of enforcement of the State of Ohio nursing home licensing requirements for the standards of treatment and care of nursing home residents or patients and the resultant or related actual level or quality of treatment and care provided to AFA recipients who are residents of nursing homes.
2. The appropriateness of procedures and practices employed in placing AFA recipients in nursing homes. Suggestions were made that certain unethical or improper practices are involved in that individuals responsible for referring persons for placement, or for actual placement, may receive payment from certain nursing home operators for certain concessions and that State money allowances for nursing home care may be established in many cases at a rate higher than is appropriate under the State's established criteria for the type of care required by individual recipients.
3. The adequacy of State controls over payments to vendors, including medical or health care practitioners and pharmacies. The suggestion was made that certain vendors may bill and be paid for services or goods which are not actually required by AFA recipients or provided to them.

In addition to allegations relating to the areas described above, which constituted the primary bases for our inquiry, several allegations of a specific nature were made. Also, certain allegations were made which relate to the sources of financing for nursing home operations and the possible business, political, or criminal connections of nursing home operators. Although we made limited inquiries into certain of the specific allegations and have included comments relating thereto in this report, in general inquiry into these allegations was beyond the scope of our examination.

As our inquiry was limited to a review of the Federal, State, and county policies and procedures and selected State and county records pertinent to the allegations made, we did not attempt to independently establish the validity or invalidity of the allegations. We directed our attention to the accumulation of information and data that would assist in defining areas in which--because of the inadequacies or weaknesses in pertinent policies, procedures, or controls or because of the nature of information contained in pertinent records--practices or deficiencies of the types alleged may exist and a review or investigation in greater depth may be warranted. The extent of our inquiry into each of the areas to which the allegations relate is described in greater detail in the appropriate sections of this report.

We did not visit or review the records of any nursing homes, medical or health care practitioners, or vendors of drugs and other medical supplies. Also, although we interviewed Federal, State, and county officials and personnel, as deemed necessary, to secure information and clarification of certain policies and procedures and their application, in accordance with the agreement with the staff of the Subcommittee, we did not apprise these officials of the bases for or the results of our inquiry or obtain their comments on our findings.

FINDINGS

It is our opinion that, because of inadequacies in pertinent policies, procedures, and controls or in their implementation, practices or deficiencies of the types described in the allegations which provided the bases for our inquiry could exist without detection by appropriate authorities or, if detected, could continue without appropriate corrective action. Therefore, we believe that the results of our review, as shown in this report, demonstrate that each of the areas to which we directed our inquiry would warrant further examination or investigation, and in greater depth, to ascertain the extent to which the alleged practices or deficiencies do, in fact, exist and to develop suggestions for needed improvements in related policies, procedures, and controls.

Although our review was of limited scope and was concentrated in Cuyahoga County, we believe that the information obtained and the deficiencies and weaknesses found with respect to pertinent policies, procedures, and controls indicate that improvement in program administration may well be needed on a State-wide basis to better ensure that practices of the types indicated by the allegations do not go undetected or uncorrected.

In this connection, we found that HEW had not provided its responsible field representatives with specific instructions or guidelines for use in making continuing reviews of the State and local administration of program activities relating to providing nursing home care, medical services, and prescribed drugs for AFA recipients in Ohio. On the basis of our review of records and our discussions with responsible officials in the HEW regional office, it appears that neither the regional representatives of the Bureau of Family Services, Welfare Administration, nor the cognizant HEW

auditors have performed independent reviews of the State and county procedures and controls followed with respect to these program activities.

The findings resulting from our inquiry into the areas related to the allegations made are discussed in the following sections of this report.

ENFORCEMENT OF REGULATIONS GOVERNING
OPERATIONS OF NURSING HOMES

It was alleged that AFA recipients in some nursing homes did not receive adequate treatment and care or were kept in the homes against their will and that some nursing homes might have patients in excess of their licensed capacity.

In the State of Ohio, nursing home operators are licensed by the Director of the State Department of Health. The SDH is responsible for enforcing the State licensing requirements relating to the adequacy of facilities and standards of care, as set forth in the Nursing Home and Rest Home Licensure Law of the State of Ohio and chapter HE-17 of the Ohio Sanitary Code, promulgated by the Public Health Council of the State Department of Health.

The SDH is required to inspect licensed nursing homes at least annually and is empowered to deny or revoke, through formal administrative proceedings during which the operator is granted a hearing, the license of any operator whose home is found to be in violation of the governing requirements. An operator may appeal an order of license denial or revocation issued by the Director of the SDH to the court of common pleas of the county in which his home is located. If it appears to the court that an unusual hardship to the operator will result from the execution of the order pending determination of the appeal, the court may grant a suspension of the order. If such suspension is granted, it may not be vacated until the matter is finally adjudicated, which includes time for any appeal that may be taken from the decision of the court of common pleas.

In carrying out his responsibility for the enforcement of the licensing requirements, the Director of the SDH may authorize, in

specific cases, such variance from the licensing requirements as would not be contrary to the public interest, where the operator shows that, because of practical difficulties or other special conditions, the strict application of the requirements would cause unusual and unnecessary hardship.

The SDH performs two types of inspections of nursing homes. Health care inspections are concerned primarily with requirements relating to the personal and health care of patients, including adequacy of personnel, medication and medical care records, diet, and treatment. Sanitation inspections are concerned primarily with the sanitary conditions in the home, including toilet facilities and plumbing, food service, water supply, and the handling of garbage and refuse. Violations of prescribed standards and requirements are noted in inspection reports and brought to the attention of the nursing home operator for correction. Copies of the health care inspection reports are furnished to the State Department of Public Welfare (SDPW). Generally, however, these reports are not forwarded to the county welfare office responsible for placing AFA recipients in nursing homes.

In addition to the inspections performed by the SDH, inspections of nursing home facilities are made by State or local building and fire authorities. Copies of reports on these inspections are furnished to the SDH.

The current Ohio State plan encompassing the AFA program, which was effective July 1, 1966, and has been approved by HEW, provides that, when a recipient's health requires him to seek living arrangements where special services or nursing care can be given to him, the State agency should have at least minimum assurance that the home provides a safe, pleasant environment and

services which will help the recipient to function up to his capacity. It further provides that State licensing regulations will be some basis for determining that the home is maintained in accordance with the minimum standards prescribed by the licensing authorities. However, neither the prior plan nor the current State plan contains provisions specifying the responsibility of the SDPW or of the county welfare agencies to ensure that continuing adequate treatment and care are provided for AFA recipients residing in nursing homes.

On the basis of our discussions with officials of the SDPW and with case workers and other personnel in the Cuyahoga County agency and our review of the files of selected AFA recipients residing in nursing homes, it appears that primary reliance is placed on the licensing authorities to ensure the adequacy of treatment and care.

As part of our examination, we reviewed the reports of inspections, made by the SDH and by local building and fire authorities from January 1965 through October 1966,¹ of 79 nursing homes located in Cuyahoga County and noted recorded violations of licensing requirements closely related to the treatment and care of residents. We also reviewed the records of formal proceedings of the SDH relating to license denial or revocation actions taken against

¹In reviewing the inspection files in December 1966, we noted that, for most of the 79 homes, no inspections had been performed after September 1966. We were advised by SDH officials that, from September to the date of our review, most of the nurses and other personnel with inspection duties had been assigned full time to assist in the program for the certification of medical care facilities under title XVIII of the Social Security Act (Medicare) and that, therefore, few inspections of nursing homes were made during this period.

nursing homes in Cuyahoga County since October 20, 1965, the effective date of the present licensing requirements.

During the period covered by the inspection reports reviewed, the 79 homes had been subjected to 167 health care inspections, 149 sanitation inspections, 133 building inspections, and 135 fire inspections. With few exceptions, each home had received at least one inspection of each type. Most of the homes had received at least two health care and two sanitation inspections.

In our review, we found that 120 reports, involving 61 of the 79 homes, showed a total of 312 violations of the licensing requirements closely related to the treatment and care of residents. For example:

A total of 66 reports, involving 38 homes, cited 66 violations relating to inadequate numbers of licensed nursing personnel. The violations which were cited ranged from a situation where a home with 39 patients was in need of 1 additional licensed practical nurse to situations where a home with 93 patients employed only 1 licensed practical nurse although a total complement of at least 9 licensed nurses was required by the regulations and a home with 28 patients employed no licensed nurses although a total complement of at least 4 was required.

A total of 28 reports, involving 23 homes, cited 39 violations relating to inadequate medical supervision. The cited violations included 23 related to the admission of residents without a chest X-ray or tuberculin test being performed as required; 8 related to the administration of medications without proper authorization; and 6 related to patients not having been seen by a physician within the prescribed period of time.

A total of 35 reports, involving 30 homes, cited 45 violations relating to incomplete patient medication records. The cited violations included 18 related to incomplete, or lack of, records concerning the control and use of narcotics or barbituates; 12 related to the failure to submit the required monthly admission and discharge reports to the SDH; and 11 related to records which had not been signed as required by the responsible licensed nurse.

A total of 20 reports, involving 16 homes, cited 22 violations relating to restraint of patients. The lack of a proper physician's authorization for the use of restraints accounted for 18 of the 22 violations cited. Of the remaining cited violations, 3 related to the use of restraint devices of a type prohibited by the regulations and 1 involved an instance where 17 patients were locked up on the second floor of the nursing home in violation of the regulations.

A total of 31 reports, involving 24 homes, cited 35 violations related to improper diet planning. The majority of the cited violations related to instances where menus for meals served or special diet menus were not available.

Only three reports on three homes indicated occupancy in excess of licensed capacity.

Except with respect to violations concerning personnel requirements, the inspection reports reviewed showed only a few instances in which the same or similar violations were noted in two or more inspection reports for the same home. Of the 38 homes reported to have inadequate numbers of nursing personnel, repeated violations were reported for 22 in two or more inspection reports. The examples shown in the following schedule illustrate these situations.

<u>Nursing home</u>	<u>Date of health care inspection</u>	<u>Violation of nursing personnel requirement</u>
1.	July 1965	Only one licensed practical nurse (LPN) for 15 patients.
	Aug. 1966	Same.
		Note: For 15 patients, one LPN or registered nurse (RN) is required to be on duty at least 16 hours each day and one must be on call at all other times. This would require the employment of at least two LPNs plus relief coverage.
2.	Jan. 1965	No LPN for 37 patients.

<u>Nursing home</u>	<u>Date of health care inspection</u>	<u>Violation of nursing personnel requirement</u>
	Jan. 1966	One LPN part time for 37 patients. Note: For 37 patients, an LPN or an RN is required to be on duty at all times. To staff three shifts 7 days a week would require four LPNs or RNs.
3.	Dec. 1965	One full-time and one part-time RN and two LPNs for 69 patients.
	July 1966	Two RNs and four LPNs for 77 patients. Note: For 69 or 77 patients, one RN is required to be on duty at least 8 hours a day and two LPNs are required to be on duty at all times. This would require a total complement of at least nine licensed nurses of which at least one is an RN.
4.	Feb. 1965	One LPN for 16 patients.
	Mar. 1966	Same. Note: Requirements same as for item 1 above.
5.	Nov. 1965	One LPN for 38 patients.
	Aug. 1966	Two LPNs for 38 patients. Note: Requirements same as for item 2 above.

Although license denial or revocation action was initiated with respect to 6 of the 22 homes for which repeated violations of nursing personnel requirements were reported, in only 2 of the

6 homes was violation of these requirements cited as a basis for the action. (One of these cases is discussed in detail on pp. 18 through 20 of this report.) In 20 of the 22 homes, apparently the only action taken was to notify the nursing home operator of the nursing personnel violations each time they were found.

With respect to only 15 of the 79 homes for which we reviewed inspection reports had any license denial or revocation action been initiated subsequent to October 20, 1965. Such action had been initiated during this period against seven additional homes located in Cuyahoga County for which we did not review inspection reports. Of these seven homes, four had been closed prior to our review, one had not been shown in the SDH listing of licensed homes, and the inspection files for two were not readily available to us.

Of the 22 homes in Cuyahoga County against which license denial or revocation proceedings had been initiated, the actions with respect to 17 were taken solely on the basis of building code violations reported by local authorities. For 12 of these homes, the actions were subsequently dismissed on the basis of a temporary approval by the local authorities of a variance from the building code or a correction of the deficiency. In three of these cases, actions were again initiated at the expiration of the approved variance period or were initiated on the basis of a report of a further building code violation. Final disposition of these cases had not been made as of February 1967.

Of the other five homes against which action was taken solely on the basis of building code violations, three were denied licenses; one was licensed but with a reduced patient capacity; and, for the other, an order denying a license was appealed in the court of common pleas in the county, which in July 1966 suspended

execution of the order pending determination of the appeal. In suspending execution of the order, the court stated:

"*** the Court finds that there would be a hardship resulting to the Division of Aid for the Aged in placing their wards in suitable homes *** and it is therefore ordered that the order of the appellee (Ohio Department of Health) of May 2, 1966, refusing to renew the license herein involved is therefore suspended until further order of the Court, while this appeal is pending."

We were advised by court personnel that, although either party to the appeal action could request that this case take precedence over other pending cases, such a request had not been made and it might be 3 years before the appeal would be heard.

For the remaining 5 of the 22 homes against which license denial or revocation actions were initiated, the actions were based on violations relating to health care or on such violations together with building code violations. Although in two of these cases a license was denied, one of the two homes continued to operate pending action on the operator's application to operate the home as a rest home rather than a nursing home; we were advised by personnel of the county welfare agency that they had not been advised of the license denial and therefore considered that the home was qualified to care for AFA recipients requiring skilled nursing care. Although the order denying a license had been issued in July 1966, in February 1967 11 AFA recipients were being housed in the home, 6 at the maximum nursing care rate, 2 at the average nursing care rate, and 3 at the rest home rate.

One of the five actions based on violations relating to health care was dismissed on the basis of subsequent compliance with requirements and another resulted in licensing the home but at a reduced nursing care patient capacity.

The other of the five actions which were initiated on the basis of health care violations involved an inadequate number of professional nursing personnel. This action was dismissed in July 1966 on the basis that substantial corrective action had been taken. However, subsequent inspections of the home in August, September, and December 1966 showed repeated violations of nursing personnel and several other requirements, and an action to revoke the operator's license was initiated in January 1967. Information concerning this home obtained by us from SDH files is summarized below.

The home had a licensed capacity of 28 patients. The licensing requirements provide that a nursing home with more than 25 but not more than 50 patients must have a licensed practical nurse or a registered nurse on duty at all times.

The report on a health care inspection made of this home in September 1965 noted that an LPN was not on duty at all times and also noted a need to maintain an adequate supply of linens.

The report on a health care inspection made in March 1966 noted violations of the requirements in that (1) certain patients had not been seen by a doctor for long periods of time, (2) no LPNs or RNs were employed by the home, (3) stock drugs were on hand, (4) special diet menus were not maintained and special diets were not served, and (5) monthly reports of discharges and admissions were not submitted.

The report on a health care inspection made in April 1966 again noted that no LPNs or RNs were employed, but it did not indicate whether the other violations noted in the March inspection had been corrected.

On April 29, 1966, the SDH notified the home operator that license revocation action was being taken on the basis of the home having no licensed personnel for

28 patients. The home operator's attorney requested a hearing which was set for May 31, 1966, and subsequently postponed until July 14, 1966.

A report of an inspection made in June 1966 did not note any violation of the nursing personnel requirement. Presumably, the home had employed the necessary personnel after the April inspection. The report did note, however, that the home's record of menus was not up to date and that the quantity of meat and vegetables at mealtime was not adequate for 26 patients. The inspecting nurse commented that the noon meal consisted of sausage patties the size of quarters, one tablespoon of mixed vegetables, one tablespoon of hominy, one half slice of bread, and coffee and that the home operator blamed the cook for not cooking enough food.

Apparently on the basis of the June inspection, the SDH dismissed the revocation action on July 12, 1966.

The SDH received a letter dated June 28, 1966, from a person who identified herself as being an LPN formerly employed by the home. The letter complained that the nursing home operator was not fully clothed when she showed the LPN around the home on her first day of employment and that she (the LPN) had left the home because of conditions. She cited the striking of patients, insufficient food, and unwarranted use of thorazine, a tranquilizing drug. The letter stated also that a certain patient was covered with bed sores. The Administrator, Ohio Nursing Home Program, SDH, replied to this letter on July 5, 1966, one week before the license revocation action was dismissed, stating that action was being taken to deny the license of the home.

The SDH received another letter on July 15, 1966, from another person who identified herself as an LPN formerly employed in the home. This letter made complaints concerning the nursing home operator similar to those contained in the previous letter. The letter also mentioned the same patient as being covered with bed sores and stated that the patient was then deceased and the body had been cremated. The letter stated also that the

majority of the patients slept in rags and that patients begged for milk, bread, etc., all during the night.

Health care inspections were made at this home in August and September 1966. The report on the August inspection noted that (1) an adequate supply of linens, towels, and wash cloths was not available, (2) records of menus were not available, and (3) only one LPN was employed for 26 patients.

The report on the September inspection noted that (1) only one RN was employed part time for 27 patients, (2) bed linens were torn and ragged, (3) the size of servings observed at mealtime was not adequate, (4) records of menus were not up to date, and (5) four other violations.

In December 1966, another health care inspection was made. The report on this inspection cited eight violations including (1) only one RN part time for 28 patients, (2) patients not receiving kind and considerate care, (3) two patients found lying in urine-soaked beds, (4) a gallon of Elixer of Phenobarbital found in the basement, and (5) menus for certain diabetic diets not recorded and no evidence that the prescribed diets were being served.

On January 24, 1967, the SDH notified the home operator that license revocation was being taken on the basis of the violations disclosed in the December health care inspection and the disapproval of the building in January 1967 by the local fire department.

Information contained in the SDH inspection files relating to this home and in files which we reviewed at the county welfare agency indicated that two patients had been kept in this home against their will, one in 1965 and one in 1966, and that one of these patients had been denied visitors, in violation of requirements. This was the only home with respect to which information reviewed by us indicated that patients may have been held against their will.

In our review of the license denial or revocation actions initiated by the SDH, we noted, as is indicated by certain of the

information detailed above, certain factors which could tend to militate against the effectiveness of the existing enforcement procedures to ensure the continuing adequate treatment and care of nursing home residents. First, it appears that only violations found in the latest inspection of a nursing home are cited as the basis for action and that often, as in the cases where action was taken solely on the basis of building code violations although other violations had been found in the latest health care inspection, only the violations found in one type of inspection are cited. Also, it appears that evidence of correction of a violation, or the approval of a temporary variance at or before the time that a hearing is scheduled results in the dismissal of the action and that no provision is made for holding the action in abeyance pending evidence of sustained compliance with the pertinent requirements. Thus, if sustained compliance does not follow, a new action must be initiated, and, since only the latest inspection findings are cited, no pattern of repeated violations is necessarily shown in the subsequent action.

In addition, it is clear that, under the prescribed enforcement procedures, a nursing home operator who wishes to resist license denial or revocation action is privileged to take steps which may delay final adjudication for a considerable period of time, since he has the right of appeal to the courts and the right to request suspension of the order of license denial or revocation pending final determination of the appeal.

We discussed the enforcement program with the Administrator of the Nursing Home Program of the SDH. He stated in November 1966 that during the past year the State had taken 169 actions against nursing homes in the State and that 24 homes had been closed. He

stated that at that time 47 denial or revocation actions were pending and 20 nursing home operators had taken court actions against the State which might take as long as 3 years before final adjudication.

In his discussions with us, the Administrator indicated that, because under the existing enforcement procedures the several avenues of recourse available to nursing home operators enable them to delay or avoid final actions to deny or revoke their licenses, formal license denial or revocation actions are instituted only in cases where violations of requirements are very serious from the standpoint of the health and safety of nursing home residents.

We also specifically discussed with the Administrator the numerous violations of nursing personnel requirements shown in the inspection reports which we reviewed. He advised us that, because of the critical shortage of nursing personnel, particularly in the Cleveland area, a practical approach had to be taken to the enforcement of the nursing personnel requirements. He stated that, if formal actions were initiated with respect to all homes which did not meet these requirements but which were otherwise in substantial compliance with the regulations, chaos would result.

He advised us also that effective in January 1967 the nurses who previously made health care enforcement inspections would act only as consultants to nursing home operators to assist them in improving conditions and in improving the utilization of personnel; they would make three visits to each nursing home in 1967. He stated that these nurses would no longer write up violations and that enforcement inspections, if any, would be made by other personnel. He indicated that this change in procedure was based on the belief that the consultation and assistance approach,

particularly in the area of the effective utilization of skilled nursing personnel in the care and treatment of patients, would be of greater benefit than the approach used in the past had been.

In a subsequent discussion of the changed duties of the nurses, in February 1967 the Administrator advised us that the matter had been further considered and that it had been decided that one of the three nurses' visits to each home in 1967 would be for the purpose of a health care enforcement inspection similar to those previously made.

We believe that the results of our preliminary inquiry support certain conclusions as to the desirability of or the need for a further review, and in greater depth, of the adequacy of the controls exercised by the State of Ohio in providing assurance that residents of nursing homes, including AFA recipients, receive on a continuing basis the quality and level of care envisioned by the governing State licensure requirements.

It seems clear that nursing home operators who are not otherwise motivated to provide care of the desired level or quality may delay for long periods or perhaps avoid indefinitely any meaningful penalty for not meeting the prescribed requirements, either through taking full advantage of the prescribed administrative or judicial processes or through only temporarily correcting cited violations of requirements.

It seems clear also, from our discussions with the Administrator of the Ohio Nursing Home Program, that the vigorous and strict enforcement of the licensure requirements may be hampered by practical considerations resulting from shortages of qualified nursing personnel and by the avenues of recourse available to the nursing home operators against whom action is initiated.

The above conclusions suggest to us that a further review of the subject by appropriate authorities would be desirable to assess the extent to which treatment and care in nursing homes may in fact be inadequate or improper and to consider the need for appropriate corrective action. Also, the nature of the practical considerations which appear to have militated against the strict enforcement of the State's requirements suggests that it may not be possible to confine corrective action solely to measures directly related to the State's enforcement machinery; that is, if it is not realistic to expect full compliance with the nursing personnel requirements because of the shortage of qualified personnel, strict and vigorous enforcement of the requirements as a full solution to the problem may not now be feasible.

In addition, we believe that any further review of the subject should give consideration to whether the present method of establishing compensation to nursing homes for the care of welfare recipients is consistent with the objective of the adequate care and treatment of nursing home residents.

In this connection, the State bases the amount of financial assistance to be provided to welfare recipients who require nursing home care on a budgeted need figure which includes a fixed amount (\$200 a month is allowed for "maximum nursing care" and \$165 a month is allowed for "average nursing care" as defined by the State and discussed on page 28 of this report) for the cost of nursing home care. Also, the State requires that nursing homes accepting welfare patients accept the amount fixed by the State as full compensation.

The amounts allowed by the State do not vary on the basis of the actual costs incurred by individual nursing homes in providing the required care.

It appears to us that allowing a nursing home a fixed amount of compensation which does not consider the actual costs of the nursing home may generate economic pressure on the nursing home to reduce costs at the sacrifice of the quality or level of care provided or to avoid incurring increased costs necessary to improve the level or quality of care. This economic pressure, which would vary from nursing home to nursing home depending on the portion of its patient population that consisted of welfare recipients, would stem from the fact that, irrespective of the amount of costs actually incurred, for the services of nursing personnel for example, the amount of compensation would remain the same. In these circumstances, the operator has no financial incentive to improve the level of care but does have such an incentive to keep costs as low as possible.

PROCEDURES FOR PLACEMENT OF AID FOR THE AGED
RECIPIENTS IN NURSING HOMES AND DETERMINATION OF
NEED FOR VARIOUS LEVELS OF CARE PROVIDED RECIPIENTS

It was alleged that numerous admissions had been made to nursing homes without proper supporting documentation and that many AFA recipients so admitted were not in need of nursing home care or treatment. It was alleged also that the majority of AFA recipients had been admitted to nursing homes on the basis that they were in need of the maximum level of care which, under existing regulations, warrants a higher rate of payment than the average level of nursing home care and treatment.

It was alleged also that doctors had been cooperating with the nursing homes in getting patients who were in little need of care into the homes. In addition, it was alleged that caseworkers and others were possibly being paid by nursing home operators for referring AFA recipients to the homes in many instances where the need for nursing home care or for the level of care determined to be required was questionable.

On the subjects of the level of care and the need for care, it was alleged also that the preadmission diagnosis did not in many cases agree with the diagnosis by the nursing home physician.

In light of the fact that certain patients admitted to nursing homes may require only a small amount of care compared with certain other patients, it is conceivable that the nursing home operator may find it beneficial to pay welfare workers for referring to his home patients who are in need of little care or to seek cooperative arrangements with physicians designed to secure patients needing little care. Specific inquiry into such situations, however, was beyond the scope of our review, and no specific information came to our attention which would either support or negate the validity of the allegations.

With respect to the allegation of disparities between the diagnoses by the physician referring the patient and by the nursing home physician, which implied that the nursing home doctor would attempt to justify that the condition of the recipient required a level of care warranting payment at a higher rate, we found that, in most of the cases reviewed, there were no significant differences in the diagnoses. In this connection, however, and as described in more detail on page 32 of this report, the diagnosis by the physician making the referral or by the nursing home physician did not in most cases contain information which, in our opinion, would enable a proper determination to be made of the level of care needed or which, as a practical matter, would appear to play a decisive part in determining the level of care for which payment would be made.

According to provisions contained in the approved State plan, it is the responsibility of the county welfare department to certify the eligibility of welfare recipients for medical assistance. The caseworker is expected to be alert to the health care needs of each client, and, where appropriate, the caseworker should take the necessary action to obtain for the client medical diagnosis and treatment. The State plan indicates that the client's physician generally makes the decision as to whether a specific health care service is needed and that the physician's statement recommending a particular kind of care should include the physician's name and address, the date of examination, his diagnosis, and the care and treatment recommended.

The required supporting documentation for admission of an AFA recipient to a nursing home includes a statement of the physician's recommendation for special service. It also includes a statement of services to be provided, which is to be completed in part by the

nursing home operator or nurse in charge at the nursing home and in part by the cognizant welfare caseworker.

The Ohio State plan provides for the two levels of nursing home care for the purpose of determining the welfare recipient's budgeted needs; namely, maximum nursing care and average nursing care. Payment is also provided for rest home care. With regard to the type of services expected to be provided under each level of nursing home care, the Ohio State plan provides the following:

Average nursing care. Clients in this category require semi-skilled nursing care which must be provided by, or under the supervision of, licensed personnel in the nursing home. Examples of average nursing care are as follows: Observing, recording, and reporting to the appropriate person symptoms, reactions, and changes in the general physical and mental condition of the patient; routine pulse and temperature checks; full bath or equivalent; lifting the patient in or out of bed or changing positions in bed; feeding the patient; and administering prescribed medication.

Maximum nursing care. These services are of the type which would approximate hospital care for the chronically ill patient. Ordinarily, cases that will be allowed the maximum care rate will require a combination of skills and much involvement of time. This degree of nursing care requires skilled licensed personnel in attendance for the proper application of the nursing techniques required. Examples of maximum nursing care are: Use of oxygen or other special equipment; abnormal need for dressings or supplies; intravenous medication or feedings; and complete care of helpless patients.

The current monthly allowance for nursing home care in Cuyahoga County is not to exceed \$200 for those recipients considered to be in need of the maximum level of nursing home care and \$165 for those recipients requiring the average level of nursing home care.

According to the Ohio State plan, a nursing home operator may not charge an AFA recipient in excess of the allowance established

by the State for the level of care required by and given to the recipient.

The State plan provides that an allowance for rest home care at the rate of up to \$135 a month is authorized when a recipient's physical or mental condition is such that extensive help in personal services is required. Personal services refer to the assistance which may be required by a client for the many activities of daily living related to personal care and hygiene and which may be provided adequately by someone other than a licensed practical or registered nurse. Examples of personal services are: Help required in getting in and out of bed, getting to the bathroom, dressing, bathing, hair care, walking, and eating.

As part of our review, we examined the case history folders for 25 AFA recipients selected from those recipients placed in nursing homes during 1965 or 1966. Our examination revealed that the individual case folders were not complete in all respects and that certain documentation relative to the admission to nursing homes was not available.

We found in each case examined that a preadmission diagnosis by a physician attesting to the client's need for nursing home care was included in the file. In some cases, however, we found that the required statement of services to be provided had not been prepared by the nursing home operator or the nurse in charge and that the caseworker had not completed the required record with respect to the patient's apparent limitations.

With respect to determining the appropriate level of care to be provided to AFA recipients placed in nursing homes, we found no written procedures or specific instructions at either the State or county level describing methods for determining the level of care

and no description of the evidence or necessary supporting documentation relative to such determinations.

The results of our review of State and county records support the allegation that the majority of AFA recipients in nursing homes in Cuyahoga County are considered to be in need of the maximum level of care. State and county records show that about 79 percent, or 1,271, of 1,602 AFA recipients in nursing homes in Cuyahoga County as of July 31, 1966, were indicated as being in need of the maximum level of care. Also, we examined certain records in support of nursing home placements made by the AFA office of Cuyahoga County during the period August through December 1966. Our review showed that, of the 223 recipients placed in 48 nursing homes during this 5-month period, 194, or 87 percent, were designated as requiring the maximum level of care.

We were informed that the placement of AFA recipients in nursing homes and the determination of the level of care required are made in Cuyahoga County by two assistant caseworker supervisors of the county welfare agency. We were advised by the assistant caseworker supervisors that, at the time of placement, each case is discussed with the nursing home operator and agreement is reached on the level of care that is warranted.

We were advised also that, although the preadmission diagnosis provides some information and primary reliance must be placed on such information in determining the appropriate level of care, in many cases the information is not sufficiently specific concerning the patient's limitations and needs to enable an informed judgment as to the level of care required. Generally, at the time the recipient is placed, neither the assistant caseworker supervisor nor the nursing home operator has seen the patient.

We were informed further that the cognizant caseworker is expected to visit the nursing home shortly after placement and to review the appropriate health care records and the conditions relative to the care of the patient to ascertain whether the level of care determination appears to be appropriate. We were advised also that, if the nursing home operator believes that the level of care classification should be changed to provide for a higher classification, a physical examination by the nursing home physician will be requested to determine whether such change is warranted.

The assistant caseworker supervisors stated their belief that they often place recipients at the maximum level of care where only the average level of care services is required. They added that, in their opinion, the services described with respect to qualifying for the respective levels of care are somewhat unrealistic and unreasonable. One of the assistant caseworker supervisors stated that, if she experiences difficulty in securing nursing home accommodations for a recipient at the lower level of care, she then attempts to place the recipient in a nursing home at the maximum level classification. We were informed by the assistant caseworker supervisor that certain nursing home operators will not accept welfare patients at the lower level of care payment rate.

We believe that the results of our review generally confirm the statements made to us by the assistant caseworker supervisors concerning the manner in which the required levels of care are determined and suggest that such determinations are matters of negotiation with individual nursing home operators rather than matters of demonstrated need of individual recipients as determined under the State's defined criteria.

In our review of the files for 25 recipients placed in nursing homes during 1965 and 1966, we found that 24 of the recipients had

been determined to be in need of the maximum level of care. The records in 17 of the 25 cases showed that the caseworker had visited the AFA recipient in the nursing home shortly after placement was made; in none of the cases was a change indicated in the level of care initially established.

In reviewing the case files, we found that in most cases the preadmission or subsequent diagnoses were of a general nature and did not provide sufficient information relative to the type of services to be provided or to those conditions which should be evaluated and considered in making a proper determination, in accordance with the State's criteria, of the level of care needed.

For example, in one case, the preadmission diagnosis of the examining physician showed that the client had arteriosclerosis and was nearly blind in the left eye. The nursing home doctor indicated agreement with this diagnosis and added to the diagnosis the term "senility." This recipient was considered at the time of placement to be in need of nursing home care at the maximum level. The comments of nursing home personnel and the comments prepared by the caseworker after placement of the individual provided no additional pertinent information but indicated concurrence in the level of care determination that had been made.

In addition to our review of the 25 case files, we found that one home licensed as a nursing home had been reclassified in February 1966 as a rest home. We examined the case history folders for all AFA recipients who were residents of the rest home in November 1966 and found that 7 of the 12 recipients were in the home prior to the time that the home was reclassified.

A further analysis of these case records indicated that the seven AFA recipients had previously been considered as in need of the maximum level of care; however, after the home was reclassified

as a rest home, the grants to the seven recipients were immediately reduced to the level authorized under existing regulations for rest home care. For two of the seven recipients, available information relating to periods both prior to and subsequent to the reclassification of the home showed no significant changes in their physical condition or in the type of service or care needed and no information relative to a determination that rest home care rather than nursing home care was required.

In two other cases, we found that, although the level of care and the amounts of the grants were reduced, a redetermination of the clients' condition had not been made prior to such actions. In the remaining three cases, the descriptions of the clients' physical condition did not indicate any significant change in their condition or any statement relative to the type of service and care provided from the time the clients were receiving maximum care to the time that they were receiving rest home care; however, the case records did indicate that a physician had stated that rest home care was required.

Also, we found that transfers of AFA recipients had been made from two other nursing homes, which had been required to reduce the number of patients. We found that three AFA recipients had been transferred to a rest home and that the assistance allowances had been reduced accordingly.

Our review of the case files for these three recipients did not disclose any information with respect to a change in the clients' physical condition or need for care which would warrant the change that was made in the level of care. We were informed by the assistant caseworker supervisor responsible for the placement that, although the case records did not show that the physical condition

of these recipients had improved to the point where only rest home care was needed, the nursing home doctor, the nursing home operator, and the nursing home nurse had been consulted before the decision was reached as to which recipients should be moved to the rest home.

We believe that the results of our review clearly indicate that the majority of recipients are placed in nursing homes at the higher level of care and that adequate information is not available at the time of placement to enable, in all cases, an informed determination of the level of care needed. Furthermore, we believe that those services described in the Ohio State plan as being necessary in qualifying for the maximum level of care require rather intensive nursing care and treatment and that it is questionable that this type of care would be provided to the vast majority of recipients.

Additionally, the seemingly arbitrary reclassifications that were made in the designated level of care in certain cases, apparently on the basis of actions such as those effecting a change in the classification of a home or a change in location of a recipient, indicate that an evaluation of the patient's specific needs may not, in many cases, be the determining factor.

As evidenced by the above facts, we believe that determinations of the level of care may be primarily matters of negotiation between the county welfare personnel charged with the placement of AFA recipients and the nursing home operators or administrators.

CONTROLS OVER PAYMENTS TO PRACTITIONERS
FOR SERVICES PROVIDED TO
AID FOR THE AGED RECIPIENTS

Several allegations were made which relate to indicated inadequate controls over payments made for services billed by practitioners as having been provided to AFA recipients. Specifically, it was alleged that:

1. Certain medical doctors and podiatrists billed and were paid for a large number of visits to recipients.
2. Billings by some practitioners may be automatic with no visits having actually been made.
3. Billings were not always made within the required number of days after the claimed visit.
4. In some cases, nursing home records for the patients did not show visits billed for by practitioners.
5. Payment was made for services to one patient by a physician who was not a physician registered in the State of Ohio.

Our examination into these allegations was limited to reviews of State policies and procedures relating to payments for practitioners' services and to analyses of payment records relating to selected practitioners and selected AFA recipients. We did not visit nursing homes or review their records or in any other way attempt to independently ascertain whether the services for which bills were submitted and paid were actually provided.

Also, although we made certain tests designed to detect payments to unregistered physicians, we found no instances of such payments. We did ascertain, however, that the State's payment procedures did not provide assurance that payments are made to only registered or licensed practitioners. In our discussion of

this matter with State officials, they indicated that consideration would be given to modifying the procedures to provide such assurance.

Further, the payment data reviewed by us showed the date on which the services were performed and the month in which the State made payment but did not show the date on which the bill was submitted by the practitioner. Although we noted many instances where payment was made several months after the services were performed, we could not ascertain readily to what extent the time lapse might have been due to delays in the submission of bills. We were informed by State officials that, although it was required that bills be submitted within 90 days of the date of service, the State did not enforce the requirement.

Prior to August 15, 1966, the State's payments to practitioners for services billed as having been provided to welfare recipients were made in accordance with a fee schedule setting forth the maximum amounts which would be paid for various types of services under various circumstances. For example, the established fee for a physician's services to recipients in a nursing home was \$5 for the first patient treated and \$2 for each additional patient treated during the same visit.

Effective August 15, 1966, the State began paying for billed services on the basis of a percentage (60 percent) of the practitioner's usual charge, with the intent of subsequently increasing the percentage to the full usual charge.

Because of experienced difficulties concerning the relationship between coverage under the State's medical assistance program and coverage under the supplemental medical insurance program under title XVIII of the Social Security Act (part B of Medicare),

payments for billed physicians' services provided to AFA recipients after July 1, 1966, were temporarily suspended by the State. Therefore, our examination of State records related primarily to payments made in accordance with the fee schedule in effect prior to August 15, 1966.

The State plan in effect during the period covered by the records reviewed provided for payments for not more than 2 visits by a practitioner to an AFA recipient each month in the case of chronic illness and not more than 10 visits a month in the case of acute illness.

The State's procedures for processing practitioner bills for payment include steps for verifying that the person to whom the services were provided was eligible for aid on the date of service and steps for detecting duplicate payments. Except for the practitioner's bill, however, the State requires no evidence that the billed services were actually rendered. Also, no postpayment audit procedures, such as verifying indicated dates of service against nursing home patient care records, are regularly employed by the State to evaluate the need for the indicated services or to determine whether the services were in fact performed.

As part of our examination, we reviewed listings of payments made during the months of November and December 1965 and February 1966 to practitioners for services rendered to AFA recipients in Cuyahoga County and selected for further review the practitioners in each classification (three medical doctors, one podiatrist, one optometrist, one osteopath, and one dental surgeon) who had the most payment entries, as follows:

<u>Practitioner</u>	<u>Number of entries</u>
Medical doctor A	960
" " B	870
" " C	215
Podiatrist	750
Optometrist	140
Osteopath	286
Dental surgeon	79

No other medical doctor had more than 200 entries. Five other podiatrists had more than 200 entries as follows: 480, 360, 280, 274, and 252. The next highest number of entries for the other types of practitioners were: optometrist, 48; osteopath, 105; and dental surgeon, 19.

For each of the practitioners selected for further review, we obtained listings of all payments made by the State during the 8-month period January through August 1966 for services billed as having been provided to AFA recipients. These listings showed for each item the case number of the recipient, the first and last dates of service covered by the practitioner's bill, the amount billed for the service, and the amount and month of payment. In general, the first and last dates of service for each payment item were the same, indicating that only one visit had been made. In some cases, however, the service dates and the amounts billed and paid indicated that the bill included two or more visits, with the dates of any visits between the first and last dates of service not shown.

The total number of billed items on the listings for each of the selected practitioners and the total amount of State payments to the practitioners during the 8-month period are shown in the following schedule.

	<u>Number of billed items</u>	<u>Total amount paid</u>
Medical doctor A	2,989	\$12,909
" " B	3,820	8,856
" " C	756	3,580
Podiatrist	3,138	13,468
Optometrist	506	7,244
Osteopath	767	3,737
Dental surgeon	44	1,443

From the listings, we reviewed the dates on which services were indicated to have been provided by each of the selected practitioners to a number of welfare recipients to ascertain whether any regular schedule or pattern appeared to have been followed in visiting the patients and rendering bills. The number of recipients and billed items included in our review for each practitioner and the results of our analyses are described below. In our analyses, we excluded billed items where service dates prior to June 30, 1965, indicated delays either in submitting bills or in processing payments.

Medical doctor A--We reviewed the listing for indicated services to 10 recipients and found 109 billed items which indicated a total of 117 visits for which the doctor was paid a total of \$504. Service dates for the 10 recipients covered a period from September or October 1965 to March or April 1966, or from 6 to 8 months. Except in the case of 1 recipient for which a total of 23 visits were indicated with a pattern suggesting periods of acute illness, the number of indicated visits per recipient ranged from 8 to 15, with 1 or 2 visits having been made each month in a fairly regular pattern.

Medical doctor B--We reviewed the listing for indicated services to 20 recipients and found 259 billed items, indicating a total of 259 visits for which the doctor was paid a total of \$643. Service dates for 14 of the recipients covered a period from September or October 1965 to May or June 1966, or from 9 to 10 months; the number of indicated visits per recipient

ranged from 11 to 18, with 1 or 2 visits having been made each month in a fairly regular pattern. For the remaining 6 recipients, service dates covered a period from February 1966 to May 1966, or 4 months. The number of indicated visits for these 6 recipients was 6 or 7 with a pattern of 1 or 2 visits each month.

Medical doctor C--We reviewed the listing for indicated services to 10 recipients, which showed 81 billed items, indicating a total of 95 visits for which the doctor was paid a total of \$383. Service dates covered a period from September or October 1965 to April or May 1966, or from 8 to 9 months. Except in the case of 2 recipients for which 13 and 15 visits were made, the number of indicated visits per recipient was 8 or 9, with 1 visit having been made each month in a fairly regular pattern.

Podiatrist--We examined the listing for indicated services to 23 recipients, which showed 184 billed items, indicating a total of 158 visits for which the podiatrist was paid \$811. Service dates for 18 of the recipients covered a period from September or October 1965 to May 1966, or 8 or 9 months. Service dates for the remaining 5 recipients covered 1 to 4 months during the same period. Generally, visits were made to the 23 recipients on a monthly basis, with about 16 percent of the visits resulting in two billed items, indicating that a service such as minor surgery was performed in addition to the regular visit.

Optometrist--We examined the listing for indicated services to 12 recipients, which showed 24 billed items, indicating a total of 12 visits, or 2 billed items for each visit to each recipient. Apparently, the billed items for each recipient consisted of a charge for an examination (\$10) and a charge for glasses (\$17.50, \$18.50, or \$19.50). The optometrist was paid a total of \$348 for the 12 visits.

Osteopath--We reviewed the listing for indicated services to 10 recipients, which showed 71 billed items, indicating a total of 91 visits for which the osteopath was paid a total of \$408. Service dates covered a period from September or October 1965 to April or May 1966, or from 7 to 9 months. For

two recipients as many as three visits were indicated in a single month; however, the number of visits ranged from 5 to 14 with generally one or two visits having been made each month in a fairly regular pattern.

Dental surgeon--We examined the listing for indicated services to 21 recipients and found 28 billed items, indicating a total of 42 visits for which the dental surgeon was paid a total of \$1,382.50. Except for single visits for three recipients and three visits each for three other recipients, only two visits were made for each recipient. The only discernible pattern was a small charge for the first visit, indicating, perhaps, only an examination, and a larger charge ranging from \$5 to \$149, indicating the providing of dental work or dentures on the second visit.

Because the analyses described above showed fairly regular patterns of indicated services for certain practitioners, we performed further analyses with respect to the three medical doctors, the podiatrist, and the osteopath. For each of these practitioners, we scheduled, on a day-by-day basis, all visits indicated to have been made during 1 calendar month. For at least 1 day of the month for each practitioner, we obtained and scheduled the addresses of the recipients for which services were indicated and plotted their locations on a map of the Cleveland area.

The results of these further analyses are described below.

Medical doctor A--We selected the month of January 1966 for the analysis of the number of recipients which were visited each day, with the following results.

<u>Day of</u>		<u>Number of</u> <u>recipients</u> <u>visited</u>	<u>Day of</u>		<u>Number of</u> <u>recipients</u> <u>visited</u>
<u>Month</u>	<u>Week</u>		<u>Month</u>	<u>Week</u>	
1	Sat.	-	17	Mon.	4
2	Sun.	-	18	Tues.	5
3	Mon.	71	19	Wed.	8
4	Tues.	34	20	Thur.	6
5	Wed.	56	21	Fri.	4
6	Thur.	5	22	Sat.	8
7	Fri.	33	23	Sun.	-
8	Sat.	10	24	Mon.	9
9	Sun.	-	25	Tues.	6
10	Mon.	8	26	Wed.	11
11	Tues.	16	27	Thur.	10
12	Wed.	22	28	Fri.	10
13	Thur.	6	29	Sat.	2
14	Fri.	12	30	Sun.	-
15	Sat.	3	31	Mon.	3
16	Sun.	-			

Total visits indicated for specific dates 362

Because many of the billed items, indicating that more than two visits were included in the item, showed a first day of service in January and a last day of service in a subsequent month, it is probable that a significant number of January visits which were billed by medical doctor A are not included in the above schedule. On the basis of the first and last dates of service shown for these billed items, the number of visits included in the billed items as indicated by the amounts billed and paid, and the doctor's apparent pattern of visiting AFA patients, as shown by our analysis discussed on page 39, we estimate that about 159 visits made during the middle part of the month are not included in the schedule.

For the visits included in the schedule, we estimate that the doctor was paid about \$1,132. The estimated 159 additional visits would represent about \$327 in paid services.

We plotted the locations of the indicated visits for January 3 and 5 on a map of the Cleveland area and found that 68 of the indicated visits on January 3 were in one nursing home. The

other three visits were at separate locations close to the nursing home.

Of the 56 indicated visits on January 5, 46 were in one nursing home, 2 were at one other location, and 7 were at separate locations, all within the same general area. The other visit was at a hospital several miles away.

Medical doctor B--We selected the month of February 1966 for the analysis of the number of recipients which were visited each day with the following results.

<u>Day of</u>		Number of recipients <u>visited</u>	<u>Day of</u>		Number of recipients <u>visited</u>
<u>Month</u>	<u>Week</u>		<u>Month</u>	<u>Week</u>	
1	Tues.	-	15	Tues.	1
2	Wed.	-	16	Wed.	3
3	Thur.	-	17	Thur.	-
4	Fri.	-	18	Fri.	2
5	Sat.	-	19	Sat.	4
6	Sun.	-	20	Sun.	-
7	Mon.	-	21	Mon.	-
8	Tues.	6	22	Tues.	14
9	Wed.	7	23	Wed.	-
10	Thur.	90	24	Thur.	31
11	Fri.	67	25	Fri.	86
12	Sat.	23	26	Sat.	24
13	Sun.	48	27	Sun.	79
14	Mon.	-	28	Mon.	<u>2</u>
Total visits for month					<u>487</u>

For the 487 recipients visited in February, the doctor was paid \$1,486.

For further analysis, we plotted the locations of the indicated visits for February 27, a Sunday, on a map of the Cleveland area. We found that 73 of the 79 indicated visits were in four nursing homes (30, 27, 14, and 2 visits made to the four homes, respectively) close to one another. The other 6 visits were at separate locations, 2 visits about 5 miles

southeast of the nearest nursing home, 2 visits about 7 miles west of the nursing home, and 1 visit near the nursing homes. We estimate that travel between these locations would involve a distance of about 30 miles within the Cleveland metropolitan area.

Medical doctor C--We selected the month of February 1966 for the analysis of the number of recipients visited each day, with the following results.

<u>Day of</u>		<u>Number of</u> <u>recipients</u> <u>visited</u>	<u>Day of</u>		<u>Number of</u> <u>recipients</u> <u>visited</u>
<u>Month</u>	<u>Week</u>		<u>Month</u>	<u>Week</u>	
1	Tues.	2	15	Tues.	4
2	Wed.	5	16	Wed.	-
3	Thur.	2	17	Thur.	2
4	Fri.	11	18	Fri.	3
5	Sat.	-	19	Sat.	-
6	Sun.	-	20	Sun.	-
7	Mon.	4	21	Mon.	6
8	Tues.	1	22	Tues.	3
9	Wed.	4	23	Wed.	-
10	Thur.	5	24	Thur.	5
11	Fri.	5	25	Fri.	-
12	Sat.	-	26	Sat.	4
13	Sun.	2	27	Sun.	1
14	Mon.	4	28	Mon.	<u>8</u>
Total visits for month					<u>81</u>

For the 81 recipients visited in February, the doctor was paid \$375.

For further analysis, we plotted the locations of the indicated visits for February 4 on a map of the Cleveland area. We found that, at three nursing homes close to one another, 4, 3, and 2 recipients were visited. The other two visits were at separate locations near the nursing homes.

Podiatrist--We selected the month of February 1966 for the analysis of the number of recipients visited each day, with the following results.

<u>Day of</u>		<u>Number of</u> <u>recipients</u> <u>visited</u>	<u>Day of</u>		<u>Number of</u> <u>recipients</u> <u>visited</u>
<u>Month</u>	<u>Week</u>		<u>Month</u>	<u>Week</u>	
1	Tues.	17	15	Tues.	9
2	Wed.	12	16	Wed.	11
3	Thur.	15	17	Thur.	9
4	Fri.	15	18	Fri.	12
5	Sat.	7	19	Sat.	6
6	Sun.	18	20	Sun.	2
7	Mon.	20	21	Mon.	10
8	Tues.	15	22	Tues.	9
9	Wed.	15	23	Wed.	3
10	Thur.	14	24	Thur.	2
11	Fri.	8	25	Fri.	17
12	Sat.	3	26	Sat.	1
13	Sun.	32	27	Sun.	2
14	Mon.	13	28	Mon.	<u>3</u>

Total visits for month 300

For the 300 recipients visited in February 1966, the podiatrist was paid \$1,467.

For further analysis, we plotted the locations of the indicated visits for Sunday, February 13, 1966, on a map of the Cleveland area. We found that 26 of 32 indicated visits were made at one nursing home. The remaining six visits were at separate locations, one north of the nursing home, two east, one south, one southwest, and one west, at distances ranging from one-half mile to 10 miles from the nursing home. We estimate that travel between these locations would involve a distance of about 39 miles.

Osteopath--We selected the month February 1966 for the analysis of the number of recipients visited each day, with the following results.

<u>Day of</u>		<u>Number of</u> <u>recipients</u> <u>visited</u>	<u>Day of</u>		<u>Number of</u> <u>recipients</u> <u>visited</u>
<u>Month</u>	<u>Week</u>		<u>Month</u>	<u>Week</u>	
1	Tues.	-	15	Tues.	1
2	Wed.	4	16	Wed.	3
3	Thur.	-	17	Thur.	-
4	Fri.	1	18	Fri.	1
5	Sat.	3	19	Sat.	1
6	Sun.	-	20	Sun.	1
7	Mon.	11	21	Mon.	5
8	Tues.	7	22	Tues.	11
9	Wed.	1	23	Wed.	3
10	Thur.	1	24	Thur.	4
11	Fri.	1	25	Fri.	7
12	Sat.	9	26	Sat.	-
13	Sun.	-	27	Sun.	-
14	Mon.	-	28	Mon.	<u>5</u>

Total visits for month 80

For the 80 recipients visited in February, the osteopath was paid \$314.

For further analysis, we plotted the locations of the indicated visits for February 7 and 22 on a map of the Cleveland area. We found that 7 of the 11 indicated visits on February 7 were in one nursing home. The other four visits were at separate locations close to the nursing home.

Of the 11 indicated visits on February 22, 8 were at two nursing homes (5 and 3 visits, respectively) within 2 miles of each other. The remaining three visits were at separate locations, all within the same general area as the nursing homes.

In addition to the results of the analyses discussed above, we noted some instances where payment listings showed dates of service to an individual AFA recipient by two different medical doctors only a few days apart.

We are not in a position to evaluate, on the basis of our inquiry, whether the services for which the above practitioners submitted bills to the State were in all cases performed or necessary to the proper medical care and treatment of the AFA recipients involved. We believe, however, that the pattern of quite frequent and regular visits indicated by our analyses for certain of the practitioners and the number of patients indicated to have been seen by these practitioners on single days suggest that the services for which bills were submitted, if performed, were provided as a matter of routine and in some cases may not have been substantial. Specifically, we believe that these circumstances are suggested by the information shown above with respect to medical doctors A and B and the podiatrist.

Therefore, considering that the State at present employs no regular procedures or controls to help ensure that practitioners' services for which billings are received were actually provided and were reasonably necessary for the proper medical care and treatment of the AFA recipients involved, we believe that further review or investigation of this subject, and in greater depth, to evaluate the extent to which program abuses may in fact exist and to consider means by which improved control over this aspect of the program may be achieved is warranted. We believe that the desirability of such a further study in this area is enhanced by the recent change in the State's payment policy which provides for payments based on the practitioner's usual charges rather than on the relatively modest fee schedule which was in effect during the period considered in our inquiry.

CONTROLS OVER PAYMENTS FOR DRUGS
PROVIDED TO AID FOR THE AGED RECIPIENTS

It was alleged that certain questionable practices existed relative to the procurement of and payment for drugs provided to AFA recipients who resided in nursing homes in the Cleveland, Ohio, area. The allegations indicated that three pharmacies claimed payment for a major portion of the drugs provided to AFA recipients in nursing homes in the county and that payments were made to pharmacists for drugs which had not been ordered by a physician or provided for the use of the recipient.

Our examination into these allegations was limited to a review of State and county policies and procedures relating to payments for drugs provided to AFA recipients and to analyses of payment records relating to selected pharmacists and selected recipients. We did not visit pharmacies or nursing homes to review their records to independently ascertain whether drugs for which bills were paid were actually prescribed or otherwise authorized or were actually received. The results of our review indicate that the State and county procedures do not provide a reasonable degree of assurance that the payments are made for drugs that are prescribed by an authorized practitioner or that the drugs have been provided to AFA recipients, and they support the allegation that a small number of pharmacists are claiming payment for substantial quantities of drugs supplied to AFA recipients.

Under the approved Ohio State plan dated July 1, 1966, covering health care services provided under the recently authorized title XIX (medical assistance program) as well as under the former State plan covering the AFA program, payments may be made by the State for those drugs and medical supplies requiring a prescription

which are provided to AFA recipients, including those residing in nursing or rest homes.

The Ohio State plan provides that physicians shall write or telephone prescriptions for AFA recipients in the same manner as for nonwelfare patients. The pharmacist receiving the prescription, according to instructions issued by the State Department of Public Welfare (SDPW) to pharmacists serving AFA recipients, is required to verify that the person for whom the drugs are prescribed is an eligible welfare recipient. Prescription orders for drugs dispensed to welfare recipients are required to be maintained by pharmacists in the same manner as any other prescription order and in full compliance with applicable State and Federal laws.

Ohio State laws governing the operation of licensed pharmacists provide that prescriptions received by word of mouth, telephone, telegraph, or other means of communication be recorded in writing by the pharmacist and that the record so made by the pharmacist shall constitute the original prescription to be filled by the pharmacist. All prescriptions are required to be preserved on file at the pharmacy for a period of 2 years and to be made available for inspection by the proper authorities.

By agreements between the SDPW and the individual pharmacists serving AFA recipients, charges for compounded prescriptions shall be made on the basis of an established pricing schedule and charges for noncompounded prescriptions shall be at the fair trade price or, for other than fair trade items, at the wholesale price plus a markup of 50 percent. An additional charge of 30 cents may be made for broken-lot prescriptions. Under no circumstances may prices charged the State exceed the charges made to nonwelfare patients. The agreements further provide that payment by the State shall constitute full payment.

We were informed by the Pharmaceutical Consultant of the SDPW, that about 94 percent of the pharmacies in Ohio have signed this agreement with the SDPW. For billing purposes, the pharmacist is required to use SDPW Form 2079 and indicate on such form data including the prescribing physician's registration number; the manufacturer, strength, quantity, and form of the drug; the price; the recipient's case number; and the code number established by the State for the particular drug dispensed. There is no provision or requirement that the form be signed by the AFA recipient or other person who received the drug on behalf of the recipient.

In our review, we found that the State's payment procedures relating to prescribed drugs include procedures to ensure that the recipient to whom the drug is dispensed is eligible at the date of service and that the drug is properly priced. At the time payment is made, however, the State has in its possession no evidence from sources independent of the billing pharmacy that the drugs were prescribed by an authorized practitioner or were actually dispensed for the use of eligible recipients. Also, the State does not regularly employ postpayment audit procedures, such as comparison of drugs for which payment was made with the recipients' medication and medical care records, to determine whether they were actually prescribed and dispensed for the use of recipients.

As part of our inquiry, we obtained listings of payments made to certain pharmacies participating in the AFA program. From such listings for the months of November and December 1965 and February 1966, we selected 18 pharmacies which were shown as having received a substantial number of payments for drugs or medical supplies and

selected for further review the pharmacies which for the 3-month period had the following numbers of payment entries.

<u>Pharmacy</u>	<u>Number of entries</u>
1	6,600
2	5,860
3	560

Of the remaining 15 pharmacies, 12 had less than 500 entries and 3 had between 500 and 1,000 entries. Although three pharmacies had a greater number of entries than pharmacy No. 3 shown above, our decision to select pharmacy No. 3 for further review was prompted by an indication that this pharmacy was among those referred to in the allegations.

We obtained listings of vendor payments for the 8-month period ended August 1966 for the three pharmacies. The payments made to these three pharmacies during this period for drugs or medical supplies provided to AFA recipients were as follows:

<u>Pharmacy</u>	<u>Number of entries</u>	<u>Amount paid</u>
1	22,848	\$105,400
2	16,075	81,900
3	1,283	5,100

A further analysis of the vendor payment listings indicated that frequent payments made on behalf of certain recipients were for a substantial number of drugs shown as having been provided in a single day. We selected for further examination vendor payment records for nine recipients located in various nursing homes, who were provided a relatively high volume of drugs by the three pharmacies. The results of our review are shown in the following schedule.

<u>Pharmacy</u>	<u>Recipient</u>	<u>Service period covered (months)</u>	<u>Number of payment entries</u>	<u>Number of different type drugs (note a)</u>
1	A	11	84	19
1	B	9	73	33
1	C	10	93	29
2	D	12	133	27
2	E	11	106	30
2	F	12	83	14
2	G	10	55	21
3	H	14	72	26
3	I	10	46	9

^aCertain entries indicated no description of the drug; therefore the number of different types of drugs shown may be slightly understated.

We found that, for certain of the recipients included in the above schedule, from 9 to 18 different drugs were reported as being supplied in a single day.

In addition, we found that substantial quantities of a variety of drugs were indicated as having been supplied to AFA recipients. For example, for recipient D during the period July 20, 1965, to June 28, 1966, we found the following:

<u>Drug code number</u>	<u>Description of drug (note a)</u>	<u>Strength (note a)</u>	<u>Number of deliveries (note b)</u>	<u>Total quantity delivered</u>
9513	Achromycin I.M.	250 mg.	1	6 inj.
3262	Achromycin V.	250 mg.	3	84 cap.
3026	Alertonic	-	8	192 oz.
5414	Alevaire	-	5	360 cc.
3208	Benylin Expectorant	-	2	16 oz.
5284	Codeine	1/2 gr.	1	20 tab.
3004	Darvon Compound	65 mg.	7	700 cap.
4415	Decaspray	-	6	540 gm.
0039	Digitoxin	0.1 mg.	5	220 tab.
3668	Dimetapp	-	1	60 tab.
3006	Diuril	500 mg.	5	150 tab.
3685	Duracillin AS	300 .U	6	70 cc.
3053	Equanil	400 mg.	7	410 tab.
0767	Ephedrine	3/8 gr.	6	600 cap.
3042	Hydrodiuril	50 mg.	1	30 tab.
5225	Isuprel	1-200	6	140 cc.
7041	Isuprel Mistometer	-	6	105 cc.
3598	Kaon	-	7	192 oz.
3372	Maalox	-	10	408 oz.
3484	Mercuhydrin	-	2	20 cc.
3610	Mylanta	-	2	156 oz.
3896	Neocortef	1%	6	120 gm.
3115	Nembutal	1-1/2 gr.	7	210 cap.
4612	Optihist	-	3	45 cc.
3380	Ritalin	10 mg.	2	160 tab.
3014	Thorazine	75 mg.	9	380 cap.
3244	Vasodilan	10 mg.	1	100 tab.
0155	(Description of drug not shown on Ohio welfare drug code listing)	-	1	-
0000	(Drugs for which a welfare code not shown on vendor payment listings)	-	7	-

^a Description and strength of drug obtained from Ohio welfare drug code listing dated November 2, 1966.

^b Indicates number of times a particular drug was delivered; in many cases quantity of the drug delivered varied.

We discussed with State and county welfare personnel the administration of, and the controls exercised over, the procurement and dispensing of drugs to AFA recipients. The Pharmaceutical Consultant of SDPW, advised us that a preaudit of vendors' invoices submitted to the SDPW is made. For the most part, this preaudit consists of determining whether the price billed is within the allowed limits spelled out in the agreement with the pharmacists, whether the quantities appear to be appropriate, and whether the required billing form has been properly completed in all respects.

We were advised that, in those cases where there appears to be a defect in the billing, the pharmacist concerned is requested to provide the additional needed information. We were further advised by the Pharmaceutical Consultant that, if considered necessary, he visits the particular pharmacist to discuss the billings and ascertain the propriety of the claim.

Correspondence which we reviewed indicated that on several occasions claims for payment to one pharmacy (indicated above as No. 2) had been questioned by the SDPW because the recipients involved had died and their names had been removed from the welfare rolls prior to the date on which the drugs were reportedly provided.

Also, in one instance where an unusual number of drug invoices had been submitted to the SDPW on behalf of a recipient located in a certain nursing home, we were advised that the Pharmaceutical Consultant, accompanied by a registered nurse from the Department of Public Welfare, made a visit to the concerned nursing home to examine the medication records for two AFA recipients. The nurse advised us that they found that the medical records of the patients were incomplete, that it was impossible to ascertain from the

records maintained which drugs had been administered to the patients, and that drugs were being kept in bulk containers rather than in separate containers labeled with the recipient's name, the identity of the drug, and the dosage to be administered. In this regard, the Nursing and Rest Home Law and Regulations, Ohio Department of Health, provide under section HE-17-17 that:

"(B) Medicines and drugs shall be given only to the individual patient or resident for whom they are prescribed, shall be given in accordance with the directions on the prescription or the physician's orders, and shall be recorded on the patient's or resident's record.

"(C) Every container of medicine and drugs prescribed for an individual person shall be properly and clearly labeled as to the following:

"(1) Date.

"(2) Name of patient or resident.

"(3) Directions for use.

"(4) Name of physician.

"(5) Identity of the drug and prescription number, if there is one."

The report prepared by the nurse regarding her visit to the nursing home indicated that, for one recipient, according to the claim made for payment as evidenced by the drug invoices submitted to the State, prescriptions for 20 different drugs had been filled; however, the report stated that the medication records were kept in many places and that, after checking the various sources of information, the nurse could verify that only 8 of these drugs were being administered to the recipient. For the other recipient, the nurse stated that prescriptions for 15 different drugs had been filled, whereas she could verify that only 4 of these drugs were being administered.

In reply to our inquiry as to what action the State planned to take with respect to the nursing home in question, we were advised by the Pharmaceutical Consultant that the consulting pharmacist for the nursing home had been instructed to correct the deficiencies and had been advised that payment would not be authorized for drug claims made for AFA recipients residing in the nursing home until such time as the situation was corrected. The Pharmaceutical Consultant further advised us that he planned to revisit the nursing home in February 1967 and that, if at that time the proper procedures for the handling of drugs had not been initiated, both the nursing home, which, according to his statement, has a terminal distributor's drug license, and the consulting pharmacist for the nursing home would be reported to the Ohio Board of Pharmacy.

The Pharmaceutical Consultant informed us that the consulting pharmacist for the nursing home is the proprietor of a pharmacy in Cleveland, Ohio. This pharmacy, having received payment for a substantial number of drugs, was one of those selected for further review and, in the schedules shown on page 51 of this report, is indicated as pharmacy No. 2.

On the basis of the results of our review, including the fact that neither the State nor the county employs adequate review procedures to provide a reasonable degree of assurance that the drugs for which bills are submitted were prescribed by an authorized practitioner and actually dispensed for the use of eligible recipients, we believe that the allegations that have been made may have some validity. The large number of bills submitted for payment by certain of the pharmacies compared with the number submitted by most pharmacies, as well as the number of prescriptions and the variety of drugs claimed on behalf of certain recipients--in some

cases in a single day--are examples of a situation which, in our opinion, warrants further investigation to ascertain the propriety of the claims made for drugs and to consider the actions necessary to establish controls and procedures to help ensure that abuses of the program are detected.

APPENDIX

Page 1

GEORGE A. SMATHERS, FLA., CHAIRMAN
 PAT MCNAMARA, MICH.
 HARRISON B. WILLIAMS, JR., N.J.
 MAURINE B. SILVERBERG, OREG.
 WAYNE MORSE, OREG.
 ALAN BIBLE, NEV.
 FRANK CHURCH, IDAHO
 JENNINGS RANDOLPH, W. VA.
 EDMUND S. MUSKIE, MAINE
 EDWARD V. LONG, MD.
 FRANK E. MOHR, UTAH
 EDWARD M. KENNEDY, MASS.
 RALPH FARBEROUGH, TEX.
 STEPHEN M. YOUNG, OHIO
 EVERETT MCKINLEY, ILL.
 FRANK GARDSON, KANS.
 WINSTON L. PROUTY, VT.
 HERALD L. FONG, HAWAII
 GORDON ALLOTT, COLO.
 JACK MILLER, IOWA
 JAMES B. PEARSON, KANS.

United States Senate

SPECIAL COMMITTEE ON AGING

(SUBCOMMITTEE TO S. RES. 111, 87TH CONGRESS)

September 20, 1966

B-114836

The Honorable Elmer B. Staats
 Comptroller General of the
 United States
 Washington, D. C.

Dear Mr. Comptroller General:

The Subcommittee on Long Term Care is in the process of making a comprehensive study of the conditions and problems in the Nation's nursing homes, reviewing the operations of Federal and State programs in this field, and reappraising the role of the Federal Government in assisting in the development of appropriate and high-quality services for the long-term patient.

In connection with its study, the Subcommittee was recently furnished copies of a confidential report concerning nursing home operations and related activities in the Cleveland, Ohio area, one copy of which was furnished to representatives of your office for consideration. Based on subsequent discussions between the Subcommittee staff and your representatives concerning the information contained in the report, I believe that it would be very helpful to the Subcommittee for your office to undertake a preliminary inquiry into certain aspects of the operation in the Cleveland area of public assistance programs which are assisted under the various titles of the Social Security Act, with a view to providing information which would be useful in determining whether a more comprehensive inquiry would be desirable.

Accordingly, I would appreciate your office making a review of the policies and procedures of the Federal, State of Ohio, and county agencies which are pertinent to the activities discussed in the confidential report and of such information as may be contained in Federal, State, and county records as would be useful in assessing the desirability of undertaking a thorough investigation into such activities.

APPENDIX

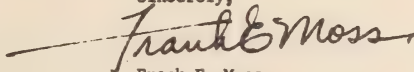
Page 2

Staats, The Honorable Elmer B.

September 20, 1966

Because of the lack of adequate information at this time, I would suggest that the precise scope of the review be defined through discussions between your representatives and Mr. Frank C. Frantz, Staff Director of the Subcommittee, with such adjustments from time to time as might be indicated by information forthcoming from the review.

Sincerely,

A handwritten signature in dark ink, reading "Frank E. Moss". The signature is fluid and cursive, with a long horizontal stroke extending to the left.

Frank E. Moss
Chairman
Subcommittee on
Long-Term Care

The CHAIRMAN. Without objection, the committee will adjourn until 10 o'clock in the morning.

(Whereupon, at 12:42 p.m., the committee adjourned until 10 a.m., Friday, March 10, 1967.)

PRESIDENT'S PROPOSALS FOR REVISION IN THE SOCIAL SECURITY SYSTEM

FRIDAY, MARCH 10, 1967

**HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.**

The committee met, pursuant to notice, at 10. a.m., in the committee room, Longworth House Office Building, Hon. Wilbur D. Mills (chairman) presiding.

The CHAIRMAN. The committee will please be in order.

Our first witness this morning is Mr. Siegfried, vice president of the Health Insurance Association of America.

Mr. Siegfried, for purposes of our record we would like you to identify yourself please, sir, by giving us your name, address, and capacity in which you appear.

STATEMENT OF CHARLES A. SIEGFRIED, VICE PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. SIEGFRIED. Mr. Chairman, I have a statement that I would like to submit for the record, but it would save time, I think, if it would be agreeable with you if I just undertook to summarize parts of it.

The CHAIRMAN. All right, just as you wish. Your entire statement will be made a part of the record, Mr. Siegfried.

(The statement referred to follows:)

STATEMENT OF CHARLES A. SIEGFRIED, VICE PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

My name is Charles A. Siegfried. I am President of the Metropolitan Life Insurance Company and Vice President of the Health Insurance Association of America. I appear before you today on behalf of the Health Insurance Association of America, which has a membership of 330 companies which write approximately 80% of the health insurance written by insurance companies.

The Association for which I speak was opposed to the enactment of Title XVIII legislation. We felt that a combination of private voluntary health insurance together with public programs for those of the aged needing assistance, was in the national interest. The Congress thought otherwise and Public Law 89-97 was enacted.

However, once this legislation became law, the insurance business undertook to contribute the knowledge gained from long experience in providing a means for financing health care and to make available their facilities in an atmosphere of cooperative endeavor to the end that this program would function as smoothly as possible.

The health insurance business, through the Health Insurance Association of America, volunteered its services to the Social Security Administration (SSA) in planning for the administration of the Health Insurance (HI) and Supplementary Medical Insurance (SMI) benefits. Five insurance companies were

named as fiscal intermediaries for the HI program. Fifteen companies were selected to act as carriers under the SMI program. These companies operate under actual-cost contracts with no provision for any payment for other than demonstrable expenses. In addition, insurance companies actively urged persons over age 65 to enroll under the SMI program.

As might be expected, with such vast programs, there continue to be areas in the field of administration that remain to be perfected. H.R. 5710 contains certain provisions aimed at improving the administrative procedures. These matters have been discussed earlier before your Committee by Mr. Daniel Pettengill. We endorse all the recommendations he made.

The impact of the Title XVIII legislation on private health insurance required a painstaking and costly readjustment of coverages so that private insurance protection would not unduly overlap the Title XVIII benefits. Most group insurance contracts, a large proportion of which are influenced by the processes of collective bargaining, had to be reconsidered on a case by case basis. Employed persons over age 65, and eligible for Medicare benefits, required special consideration. Continued protection of a younger spouse or other beneficiary of a wage earner or retiree eligible for Medicare benefits had to be assured. Essentially similar adjustments had to be made in the large number of individual policies outstanding. In a word, the entire business had to be adjusted so that it was brought into proper relationship to the Title XVIII program. This process of adjustment is still in progress.

Many insurance companies have developed and offer coverages for persons 65 and over to supplement the Title XVIII benefits. These take a variety of forms, reflecting the varying wishes of older persons for additional protection. It is clear that there is a public desire, and therefore a market, for supplemental coverages.

Proposed amendments to title XVIII

Since Title XVIII became law, a variety of proposals have been made to expand its scope. Two of these have been included in H.R. 5710.

The first, Section 127, would include non-routine foot treatment, whether provided by a physician (as at present) or by a qualified podiatrist. Such treatment by podiatrists would justifiably be limited to services of a type covered if performed by a physician. The cost of such an extension of the program should not require an increase in the SMI premium. We would not oppose this extension.

Section 125 of H.R. 5710 would extend HI and SMI benefits to include disabled beneficiaries of the DI program and the railroad retirement system, and certain other disabled persons. This would add some 1.5 million immediate beneficiaries to the Medicare program (1.2 million disabled workers, 200,000 adult persons receiving disabled children's benefits, and 100,000 disabled widows). All are under age 65.

We respectfully suggest that this proposal is one which requires considerable study for the following reasons:

1. We need to try to learn more about disabled persons under consideration in this proposal with respect to their resources and, particularly, their health care needs. The most comprehensive data with respect to the disabled are contained, so far as we know, in two documents. One is a study by the Social Security Administration¹ based on a 1960 survey. At that time there were but 500,000 DI beneficiaries, limited to ages 50 to 64, although the survey did include workers under age 50 who had been allowed a wage freeze under the OASDI program. Subsequent to the survey the DI program was enlarged, first to include workers under age 50, and then, commencing in 1966, to liberalize the definition of disability. We submit that the findings of the 1960 survey may not be representative of the DI beneficiary today. While the second collection of data² includes three years' experience with respect to workers at all ages, it contains no information with respect to DI beneficiaries under the definition of disability effective 1966. Again, we submit that the findings of the study may not be indicative of the situation today.

We conclude there is a scarcity of current data necessary to evaluate satisfactorily the nature of the need for this extension of Medicare coverage. Prin-

¹ "The Disabled Worker Under UASDI," Research Report No. 6, October 1964.

² Social Security Administration, "Insured and Disabled Workers Under the Social Security Disability Program," Research Report No. 11, 1966.

cipally, there is needed information on the income supplements which these disabled persons may have beyond the DI benefits they receive and more specific knowledge of the characteristics of their health care needs.

For wage earners, income replacement may take several forms. For some, particularly after they have reached ages 45 or 50 and have satisfied varying service requirements, there are disability retirement provisions which of late have become increasingly available under private pension plans. (It may be noted that in 1963 more than 4 out of 5 DI benefit awards each year are made to persons over age 45: 54% were ages 55 to 65 and 28% were ages 45 to 54.)³ A wage earner disabled as a result of occupational injury or sickness would receive workmen's compensation benefits. Some of the disabled are entitled to V.A. benefits. Some have disability protection through insurance company coverages, although we have no way of knowing how many DI beneficiaries are receiving such insurance benefits. We do know that increasingly larger numbers of workers are obtaining coverages that provide benefits which run for two years or longer.⁴ About 1 out of 3 DI beneficiaries recover in less than two years and an additional 2 out of 5 recover within the following two years.⁵ Among self-employed persons some level of income may be continued through participation in a profession or business ownership or through private disability insurance.

For the foregoing reasons, it is reasonable to expect that many disabled persons have sources of income in addition to their DI benefits, and that their income status could differ considerably from that of persons age 65 and over.

Some of the disabled have private health insurance protection against at least part of the costs of medical care. Although we do not know how many of the disabled have such coverage, there are more than 51 million people, including 19 million primary insureds, who now have some form of catastrophic medical expense coverage with insurance companies⁶ which in most cases will help defray some of the medical care costs even when disability has continued for six months or more. These coverages include benefits for a broad spectrum of medical care, including prescribed drugs and nursing. We wish to make it clear we do not assert that current insurance plans go as far as might be desirable, but the basic mechanism is there and progress is being made in what we think is the right direction. We believe this to be the desirable method of dealing with basic insurance needs.

As the Committee has heard earlier this week, the medical care needs of disabled persons under age 65 are different from those of the older population. DI beneficiaries, having been disabled at least six months, have relatively less need for the kind of hospital care provided under Title XVIII. The SSA indicates that among DI beneficiaries 35% have a mental or nervous disorder, and an additional 22% have a circulatory condition.⁷ These conditions often have a greater need for long-term care of various types than for short-stay hospitalization.

2. There is no doubt that some of the disabled are in need of assistance in meeting their medical bills. Some will never recover; others, while disabled, have incomes below the average for the employed population. Congress has already made provision for the medical care expenses of many of these persons. Under the Aid to the Permanently and Totally Disabled program, vendor payments for the medical care of the indigent disabled age 18 and over increased from \$3.5 million in 1951 to \$130 million for the year ending June 1965.⁸ In 1966, 583,000 persons were eligible for benefits under this program.⁹ Congress has also made available funds to assist the States in establishing and maintaining the valuable vocational rehabilitation programs, providing not only vocational guidance and training, but also medical benefits for purposes of rehabilitation, including diagnosis, treatment and surgery, and prosthetic appliances.

When the Title XIX program, enacted in 1965, is fully implemented by the States, it will provide assistance for the costs of medical care for disabled persons who qualify.

3. There is an anomaly and a violation of insurance principles in extending SMI coverage to the disabled. Enrolling persons for this coverage after they

³ Social Security Administration, Research Report No. 11, 1966.

⁴ Health Insurance Institute, "New Group Health Insurance Policies Issued in 1966," 1966.

⁵ Health Insurance Council, "The Extent of Private Health Insurance Coverage in the United States," 1966.

⁶ Social Security Administration, Research Report No. 11, 1966.

⁷ "Public Assistance: Vendor Payments for Medical Care by Type of Service," Department of Health, Education, and Welfare, Jan. 3, 1966.

⁸ Social Security Bulletin, February 1967.

have been disabled 6 months introduces what we in insurance call adverse selection. If this is done for a person under age 65, would not persons over age 65 be led to believe it discriminates against them? Would they not believe it to be consistent for them to start paying the monthly costs only when they had become disabled? The SMI program is essentially voluntary insurance, designed to provide protection against unpredictable future hazards. Permitting a person to enroll after the hazard insured against has occurred would remove the insurance principle and transform the program into one having the characteristics of a welfare mechanism. Public welfare programs already exist to aid disabled individuals who need medical assistance. Failure to maintain the distinction between the objectives and principles of these two types of programs would confuse the public and lead to doubt that sound and sensible policies are being pursued.

4. In the Social Security amendments of 1965, Titles XVIII and XIX were offered and accepted as complementary, but distinct, programs. Title XVIII was intended as a solution to the unique problem presented by the population over age 65; Title XIX was designed for the medically needy of all ages. For the population under age 65, voluntary insurance and other private resources were regarded as the primary means of financing health care, supplemented where necessary by Title XIX. The proposal under question would depart from that principle. Moreover, it would tend to weaken private responsibility in dealing with medical care costs. It would create concern as to further extension of government coverage and undermine the initiative and experimentation which have marked the field of private health insurance and have contributed to its growth and development. The result could be to impede the expansion of voluntary plans and shift an increasing burden to tax-supported programs.

5. Although highly commendable work has been done to launch Medicare, and many fine accomplishments can be recorded, it would appear that there are still many problems to be worked out before its administration can be regarded as satisfactory. Moreover, while the experience is still limited, there are indications that costs of the program may be higher than anticipated. Under these circumstances, it seems questionable whether this is the time to add new problems and costly expansions to the program.

In summary, we believe that much more needs to be known through careful study of the disabled and their medical needs before a decision is made as to what further government action, if any, is needed in this area.

Proposed amendments to title XIX

In the last session of Congress, concern was expressed by your Committee over the fact that, in the implementation of Title XIX, "a few" of the States "go well beyond what your Committee believes to have been the intent of the Congress."⁹ The report of your Committee went on to state that: "It neither expected nor intended that such care would supplant health insurance presently carried or presently provided under collective bargaining agreements for individuals and families in or close to an average income range"; and that it "never intended that federal matching under Title XIX would be made in the case of a considerable portion of the adult working population of moderate income." Your Committee thereupon cautioned "the States to avoid unrealistic levels of income and resources for Title XIX eligibility purposes."

At that time, the Chief Actuary of the Social Security Administration, Robert J. Myers, in a memorandum on this subject dated October 6, 1966 in which he referred to proposals under consideration by your Committee to modify Title XIX, estimated that reductions in federal costs would be relatively small, but stated that "these proposals will well serve as a brake on undue expansion of the program in the future." The Chief Actuary went on to say that "it seems quite likely that under 'mature' conditions, with full utilization of the provisions by those eligible to do so, and with expansion of the provisions of many of the State plans * * * the Federal cost for Title XIX as it now exists would be as much as \$3 billion per year (or even more)." He went on to note that his estimates were "based on today's population and on today's medical costs. The likely increases in the future in both of these factors would mean a further and substantial increase in the cost estimates."⁹

We concur in principle with the concerns expressed both by your Committee and the Chief Actuary.

⁹ "Limitations on Federal Participation Under Title XIX of the Social Security Act," Report, Mr. Mills from the Committee on Ways and Means, October 11, 1966.

The policy of the Health Insurance Association of America is that of supporting programs of appropriate governmental assistance in providing health care protection for those who lack resources to obtain private health insurance. A copy of that Statement of Policy is attached hereto. It is, furthermore, the position of that Association that "some limits on federal costs with respect to Title XIX programs appear desirable," as do "federal standards which provide a ceiling on federal expenses under such a plan, provided such ceiling does not prescribe the state's standard of eligibility." One approach which has appeared to be promising would be to require that the Title XIX standards for federal assistance bear a reasonable relation to the eligibility standards for cash benefits under public assistance programs for which federal funds are made available.

Section 220 of H.R. 5710 proposes to amend Section 1903 of the Social Security Act so that federal participation in medical assistance payments would not be available in payments of medical assistance to individuals and families whose income exceeds by more than 50% the highest income standards used by the State in determining eligibility under the cash assistance program.

Section 203 of H.R. 5710, however, would require that a State's standards with respect to income used in determining eligibility under all cash assistance programs shall be no less than two-thirds of the standard used for medical assistance.

These two sections must be considered jointly. In tandem, they would appear to allow the States sufficient flexibility to develop assistance programs that meet the needs of their indigent, and also encourage the States to maintain a realistic balance between the cash assistance and medical assistance programs. These amendments would seem to contain federal financial participation in Title XIX programs.

We have not had time to analyze the interaction of Section 203 and Section 220 as they relate to the principles enunciated by your Committee, mentioned previously; and while we support these principles, we believe the amendments require further study to ascertain the effects that might be experienced.

Conclusion

Mr. Chairman, on behalf of the Association for which I speak I wish to express my appreciation for this opportunity to appear before your Committee and to present to you our views. These views stem from the long experience of our member companies in providing a risk spreading means for financing medical care, as well as from our sincere appreciation as individuals of both the personal and social complexities which surround the economics of medical care.

STATEMENT OF POLICY WITH RESPECT TO MEDICAL EXPENSE INSURANCE

The Health Insurance Association of America recognizes the social responsibility of private health insurers to provide adequate health insurance to all of the people of the United States who can be reached through private insurance institutions operating in a free competitive environment.

Substantially all persons age 65 and older are now provided with basic health care expense protection through government programs. Title XIX of the Social Security Act will serve to supplement the basic program of Title XVIII (Medicare) for those older persons who qualify for additional assistance. Private health insurers play an important role for those age 65 and older as fiscal or administrative intermediaries in implementing the government programs and as the underwriters of private voluntary plans that supplement the government programs.

For persons under age 65, private health insurers will continue to take the primary responsibility for providing adequate insurance against the costs of health care. The Health Insurance Association of America supports the principle that health insurance should be provided through private means to the greatest extent possible. The Association recognizes the vital and immediate need for intensified efforts to extend private insurance protection to those still uninsured or underinsured against the costs of health care. The competitive nature of voluntary private health insurance assures further progress in providing broad coverage at reasonable cost.

For those who lack resources to obtain private health insurance, the Health Insurance Association of America supports programs of appropriate governmental assistance in providing health care protection. To the greatest extent

feasible, such programs should be designed so as not to discourage the use of private health insurance, thus reducing the need for expenditure of public funds. Insurance companies stand ready to make their knowledge and experience available to assist in the development of such programs.

Adequate health care should be available to everyone. To this end, the Health Insurance Association of America supports coordinate community planning for health care facilities and related activities to assure their availability and effective utilization. It also supports the principle of adequate financing of these facilities in a manner which will preclude the subsidy of one patient by another, and which will avoid deterioration in quality of care due to lack of funds.

Tax legislation should not discriminate between governmental and private insurers, between insurance companies and hospital or medical service organizations and organizations providing prepayment plans, or between insured and uninsured plans.

It is with full realization of the need for voluntary cooperative action that the private health insurers call upon all organizations interested in the public welfare to join in this effort to provide adequate protection to all against the costs of health care. This has been, and will continue to be, the aim of the Health Insurance Association of America.

(Approved by the Board of Directors of the Health Insurance Association of America September 7, 1966, and by the membership of the Association in special session September 8, 1966, as a restatement of the policy of the Association adopted at its Annual Meeting, May 3, 1959.)

Mr. SIEGFRIED. My name is Charles A. Siegfried. I am the president of the Metropolitan Life Insurance Co. and vice president of the Health Insurance Association of America, and I appear before you today on behalf of the Health Insurance Association of America, which has a membership of 330 companies which write approximately 80 percent of the health insurance written by insurance companies.

Fifteen of our member companies are participating in the administration of the medicare program, five of them as fiscal intermediaries for the health insurance program and 15 were selected as carriers under the supplementary medical insurance program.

As might be expected with a program as vast as this one, certain administrative questions remain to be perfected. We endorse the recommendations that were made by Mr. Pettengill in his testimony earlier this week. The impact of title XIX on private health insurance has required a very painful and costly adjustment of many outstanding plans. Many adjustments have had to be made and this process of adjustment is still continuing.

In the course of making these adjustments many companies have made supplementary coverage available and there are indications that there is a substantial market for supplemental coverage.

Since title XVIII became law a variety of proposals have been made to expand the scope of the program. Two of these have been included in H.R. 5710. The first deals with nonroutine foot treatment, whether provided by a physician or a qualified podiatrist. Such treatments by podiatrists would justifiably be limited to a type covered by a physician and we wouldn't be opposed to this extension.

The other change that is incorporated in H.R. 5710 involves the extension of both programs to the disabled and this is a subject that we think should be studied further.

In my statement I draw attention to the fact that we should have much more information than we now have as to the resources of the disabled and their medical needs, but our principal concern relates to the newness of the medicare program. It hasn't been in operation

very long. We have already noted that, while some very good work has been done to launch it, improvements need to be made and the answers have not as yet been found, and probably even more important than that is the fact that the cost picture is very uncertain and there are indications that the cost of this program may be higher than originally anticipated.

This leads us to believe that we should proceed slowly and study the matter much more carefully before extending the program with these uncertain costs and these administrative problems to the disabled group.

In addition to that consideration there is some doubt in the minds of some people as to whether the benefits that have been made available to the people over 65 are necessarily the type of benefits that are appropriate for people under 65.

Then there is a bit of an anomaly and a violation of insurance principles in the provision to extend the supplementary coverage to the disabled person at the time he is about to get benefits. He starts to make contributions or pay premiums, whichever way you want to regard it, at the time that he is about to collect benefits, and this is highly unusual in an insurance arrangement. Then, too, we think the provisions of title XIX bear on this matter and there are many uncertainties with regard to this program, which is a new one, also.

Then, as you well know, there have been many proposals for extending the benefits under the medicare program and so we don't really know what is encompassed when proposals are made to extend it to the disabled, and so for all these reasons we think it would be desirable to study the matter much more extensively than time has permitted up to this point and, as I indicated, particularly because of uncertainties in the administrative area and particularly because of uncertainties as to the cost of the present programs.

That takes me to the proposals to amend title XIX and I think it probably will be helpful if I refer to my testimony because I quote from statements from the report of your committee last year.

In the last session of Congress concern was expressed by your committee over the fact that, in the implementation of title XIX, "a few" of the States "go well beyond what your committee believes to have been the intent of the Congress."

The report of your committee went on to state that: "It neither expected nor intended that such care would supplant health insurance presently carried or presently provided under collective bargaining agreements for individuals and families in or close to an average income range" and that it "never intended that Federal matching under title XIX would be made in the case of a considerable portion of the adult working population of moderate income."

Your committee thereupon cautioned "the States to avoid unrealistic levels of income and resources for title XIX eligibility purposes."

At that time, the Chief Actuary of the Social Security Administration, Robert J. Myers, in a memorandum on this subject dated October 6, 1966, in which he referred to proposals under consideration by your committee to modify title XIX, estimated that reductions in Federal costs would be relatively small, but stated that "these proposals will well serve as a brake on undue expansion of the program in the future."

The Chief Actuary went on to say that "it seems quite likely that under 'mature' conditions, with full utilization of the provisions by those eligible to do so, and with expansion of the provisions of many of the State plans * * * the Federal cost for title XIX as it now exists would be as much as \$3 billion per year (or even more)."

He went on to note that his estimates were "based on today's population and on today's medical costs. The likely increases in the future in both of these factors would mean a further and substantial increase in the cost estimates."

We concur in principle with the concerns expressed both by your committee and the Chief Actuary.

The policy of the Health Insurance Association of America is that of supporting programs of appropriate governmental assistance in providing health care protection for those who lack resources to obtain private health insurance.

A copy of that statement of policy is attached to my statement. It is, furthermore, the position of that association that "some limits on Federal costs with respect to title XIX programs appear desirable" as do "Federal standards which provide a ceiling on Federal expenses under such a plan, provided such ceiling does not prescribe the State's standard of eligibility."

One approach which has appeared to be promising would be to require that the title XIX standards for Federal assistance bear a reasonable relation to the eligibility standards for cash benefits under public assistance programs for which Federal funds are made available.

Section 220 of H.R. 5710 proposes to amend section 1903 of the Social Security Act so that Federal participation in medical assistance payments would not be available in payments of medical assistance to individuals and families whose income exceeds by more than 50 percent the highest income standards used by the State in determining eligibility under the cash assistance program.

Section 203 of H.R. 5710, however, would require that a State's standards with respect to income used in determining eligibility under all cash assistance programs shall be no less than two-thirds of the standard used for medical assistance.

These two sections must be considered jointly. In tandem, they would appear to allow the States sufficient flexibility to develop assistance programs that meet the needs of their indigents, and also encourage the States to maintain a realistic balance between the cash assistance and medical assistance programs. These amendments would seem to contain Federal financial participation in title XIX programs.

We have not had time to analyze the interaction of section 203 and section 220 as they relate to the principles enunciated by your committee, mentioned previously; and while we support these principles, we believe the amendments require further study to ascertain the effects that might be experienced.

Mr. Chairman, on behalf of the association for which I speak I wish to express my appreciation for this opportunity to appear before you.

THE CHAIRMAN. Mr. Siegfried, we appreciate your coming to the committee this morning and giving us the viewpoint of the Health Insurance Association of America.

Are there any questions of Mr. Siegfried? Off the record.

(There was discussion off the record.)

The CHAIRMAN. Thank you, sir. We appreciate your coming to the committee.

Mr. SIEGFRIED. Thank you.

(The following letter was received by the committee:)

HEALTH INSURANCE ASSOCIATION OF AMERICA,
Washington, D.C., March 23, 1967.

HON. WILBUR D. MILLS,
Chairman, Committee on Ways and Means,
House of Representatives,
Washington, D.C.

DEAR MR. MILLS: At the close of his testimony on behalf of the Health Insurance Association of America, presented to your Committee on March 10, you submitted to Mr. Charles A. Siegfried a series of questions in writing requesting answers thereto.

The questions and his responses are as follows:

Question 1. *You mention that our most comprehensive studies of the disabled health care needs are based on old surveys at times when we only covered workers age 50 to 64 (1960) or later information but before our liberalization of the definition of disability in 1965. Don't we have another unknown quantity in this regard—the bill before us also covers disabled widows under Medicare. What do we know of their health needs?*

The point made in our testimony concerning the need for comprehensive, up-to-date information on the income levels and health care needs of disabled workers is equally valid with respect to disabled widows. We know of no comprehensive, current statistics which relate solely to the approximately 100,000 disabled widows who would be covered by Medicare benefits under the amendments contained in H.R. 5710. We believe that the disabled require substantially more rehabilitative services and related care, than the kinds of care available under Title XVIII.

Question 2. *While we are talking about disability, you are no doubt aware of our recent difficulty in estimating costs and the fact that our disability fund has an actuarial deficiency? Under the Administration bill, the disabled widows' benefit is going to be paid out of the old-age and survivors insurance fund. In order to keep track of costs, would it not be wiser to put all the benefits which are based on a determination of disability in one trust fund?*

The maintenance of separate trust funds for the programs of Federal Old-Age and Survivors Insurance, Federal Disability Insurance, Federal Hospital Insurance, and Federal Supplementary Medical Insurance is in accord with sound actuarial procedure and serves a most useful purpose. It enables the Congress, the Social Security Administration, and others concerned with the several programs to maintain close scrutiny of their financial status and progress.

Under the Administration bill (H.R. 5710) Section 105 (Widow's Benefits to Disabled Widows Under Age 62) is so drafted that it amends Section 202(e) of the Social Security Act. As you have pointed out, the consequence of this action is to require, under Section 201(h) of the Social Security Act, that benefit payments be made out of the Federal Old-Age and Survivors Insurance Trust Fund rather than out of the Federal Disability Insurance Trust Fund.

We would agree that, should this provision be enacted, the benefits should be paid out of the Federal Disability Insurance Trust Fund, and that Section 105 of H.R. 5710 should be redrafted to require this action.

Question 3. *Do your member companies have any experience underwriting health insurance for the severely disabled? Do you have any information on the costs of covering the disabled?*

If the first part of the question is stated "Do you underwrite health insurance that will cover a person once he becomes severely disabled?", the answer is "yes."

The private health insurance business seeks to extend adequate health insurance protection to all persons in the population who have the means to purchase the coverage. This is accomplished through group insurance as well as through individual policies which are guaranteed renewable. By the end of 1965, more

than 83% of the civilian population below age 65 had already been covered by some form of private health insurance. More than 51 million of such persons had obtained catastrophic or major medical expense insurance through insurance companies. This coverage offers benefits that are limited only by the aggregate reimbursement maximums, which typically are \$10,000 or more. Under such plans the disabled person's medical expenses may be paid for a long period of time. It is our hope, and belief, that such coverages will continue to grow.

Insurance is a risk-spreading mechanism and, therefore, it attempts to insure groups or individuals subject to the risk of a hazard which may occur at some unknown future time. In health insurance, the purpose is to provide persons with protection against the costs of medical care which may be incurred when they become sick or disabled; it does not generally offer protection to persons who have already become disabled.

In response to the second part of the question, an indication of the medical care costs of totally and permanently disabled persons may be gleaned from the experience of my Company, The Metropolitan Life Insurance Company. We insure our employees under a comprehensive medical expense insurance plan which covers them even after they have become totally and permanently disabled. Our studies have shown that the annual cost of this coverage per disabled employee has been about 250% of that experienced among nondisabled or temporarily disabled employees. Moreover, as we have pointed out in our testimony, the medical care needs of the disabled are different from those of the older population. An examination of our data showed that the division of costs between in-hospital expenses and out-of-hospital expenses are essentially the same for the active employees or temporarily disabled and those of the retired persons. Both groups incur about 65% of their expenses for in-hospital care and the remaining 35% for out-of-hospital medical expense. In the case of the severely disabled persons, the out-of-hospital expenses are a much higher proportion of the total expense—from 45% to 50%.

While somewhat different in nature, there are data on disabled persons available from the U.S. Department of Defense. We refer you to the publication "Medical Care for Retired Military Personnel and Their Dependents," Office of the Assistant Secretary of Defense (Manpower), June 1, 1964. This document contains the cost experience of servicemen who were retired for disability.

Question 4. *You state that we would be injecting adverse selection into the supplementary medical insurance program (Part B) if the disabled were allowed to elect this coverage. Have you actuaries computed the cost effects on the program?*

Insurance company actuaries estimate that the inclusion of the disabled into the supplementary medical insurance program (Part B) would result in adverse selection sufficient to produce an overall average cost increase of approximately 8% to 10%, during the first year of the program. This would require a corresponding increase in the \$6 SMI monthly premium of both the disabled and the aged.

The importance of avoiding adverse selection was recognized by your Committee in its report on H.R. 6675, May 29, 1965, page 35, when it discussed limiting the enrollment and reenrollment under the SMI program as being "in order to reduce the possibility of people enrolling in the program when their health deteriorates, thus increasing costs by covering people during periods of ill health who choose not to be covered during periods of good health."

Question 5. *Mr. Siegfried, you refer to the difficulties which the health insurance industry had in adjusting private protection to Medicare. What difficulties would you face in adjusting your policies if the disabled were given this protection?*

The difficulties which the insurance business would face in adjusting coverages in the event that the disabled are provided with Medicare benefits would be similar to those which we encountered in adjusting our business when Medicare was extended to persons over age 65.

The creation of a special class of insured (disabled Social Security beneficiaries) would cause considerable difficulty in administering claims under group policies. No longer would all persons within a group under age 65 be eligible for the same insured benefits. Special rate calculations would be necessary, and the record-keeping required for this special class of employees would generally add to the expenses of administration.

Problems with both group and individual insurance would be compounded by the fact that the disabled population would not be as constant as are the aged. It is our understanding that the proposal in H.R. 5710 would provide Medicare benefits to the disabled as long as they remained in that status. This would require an adjustment of our business to either cancel coverage, carve out Medicare benefits, or supplement them for all policyholders in the event that they became totally and permanently disabled after six months, with a further provision (which would greatly complicate administration) to reinstate such benefits at the time the individual returned to active employment—or otherwise went off the rolls of the federal disability insurance program.

Question 6. *As you know, we have had some disquieting testimony as to fairly steep increases in hospital per diem costs. But what about the other major element of cost estimates—hospital utilization? You will remember that we adopted a utilization rate which closely approximated the estimate of the insurance industry and which was some 20% higher than that presented by the Department of HEW? Do you have any recent information which supports our conservatism in this area? Or should we have been more conservative?*

We are of the opinion that it is too early for an ultimate picture of utilization to have emerged. Preliminary data, as we have testified, would appear to indicate that actual utilization will exceed predictions. We reach this conclusion on the basis of the following information:

A. According to the Social Security Administration, more than 2.5 million aged persons received hospital care paid for by Medicare during the first six months of the program.¹ Projecting these data to an annual basis, they represent about 5 million hospital admissions per year. With an eligible aged population of about 18.9 million persons, this would represent an annual frequency of about 265 admissions per 1,000 persons per year. This frequency would not only be considerably higher than that projected in governmental cost estimates, but would exceed the level estimated by the insurance business.

B. A release from the American Hospital Association entitled "American Hospital Association News," March 7, 1967, indicates that the average duration of stay for aged persons has increased from 11.2 days in July to 12.0 days in August to 12.5 days in September to 12.6 days in October to 12.7 days in November to 13.3 days in December. These figures compare with an average hospital stay for aged persons prior to Medicare of 12.6 days.²

Question 7. *To what extent has private commercial insurance insured the aged against the costs of the deductibles and co-insurance amounts and services not covered under Medicare? We were told by the Chief Actuary that if private insurance were to insure the deductibles and co-insurance amounts very extensively the costs of the program might be higher because an economic deterrent to the use of hospitals would disappear. Do you agree with that statement and do you believe that we will have higher costs because of this effort?*

We would agree with the Chief Actuary that deductibles and coinsurance serve as economic deterrents to the use of hospitals and other medical care, especially under private, voluntary programs. Under a compulsory governmental program, there are additional safeguards such as regulations for certification, recertification, and utilization review. Thus, there is an opportunity to exercise a measure of utilization control even in the absence of financial controls such as deductibles and coinsurance. In view of the complex interaction of all these measures it is impossible to estimate their separate effects.

Private insurance companies have provided supplementary coverage to Medicare in a number of ways. In group insurance, coverages are tailored to policyholders' demands and, consequently, vary widely. Some group plans provide benefits to the aged, except for those items covered by Medicare. Other plans preserve the deductible and coinsurance amounts contained in Medicare by allowing such amounts to be applied against the deductibles included in major medical policies.

There is also a wide variety of policies which are written on an individual basis to supplement Medicare. We are enclosing, for your information, a listing of 70 insurance companies which make available 100 different types of insurance

¹ "1966 Year-End Report: Social Security and Medicare," press statement by Robert M. Ball, Commissioner of Social Security, December 29, 1966.

² "Hospital Discharges and Length of Stay: Short-Stay Hospitals, United States, July 1963-June 1964," Public Health Service, Publication No. 1000—Series 10, No. 30, June 1966.

policies to individuals 65 and over. As indicated in the enclosed material, many of the plans provide cash benefits which the insured may use as he sees fit to pay the various expenses incurred in case of illness.

In summary, because of the wide variety of coverages written, it would be difficult to determine the extent to which benefits provided in these policies are used by policyholders in meeting the expenses of their Medicare deductible and coinsurance. It is also impossible, under a compulsory plan, to measure the separate effects of deductibles and coinsurance, and we are therefore unable to predict whether there will be higher Medicare costs due to the supplementary coverages which we provide.

Question 8. *You state on page 9 "While the experience is still limited, there are indications that costs of the programs may be higher than anticipated." What are these indications?*

The principal indications are: (1) hospital per diem costs have been climbing sharply, (2) the Social Security Administration has indicated a higher rate of hospital claim payments than might have been expected, and (3) the average duration of stay for aged persons has been steadily increasing during the period commencing July 1966.

The carrier expenditures are exceeding their original budget estimates for several reasons among which are:

(1) The required voluminous paper work for the providers entailed in claiming hospital benefits and Part B benefits for services of hospital-based physicians;

(2) The elaborate coding of information required to be reported to SSA in connection with each benefit payment, especially under Part B; and

(3) The required accumulation and analysis of complete files for the continuous sample of 5% of all Part B claims paid.

This could well indicate that SSA's cost for administrative expenses could also be higher than anticipated.

Question 9. *On page 5, you refer to the fact that private disability retirement plans are becoming increasingly available. Do these plans cover health costs? Will most commercial health insurance companies issue a policy to a person so disabled as to be on the social security disability rolls? When they do, is the premium set higher than for the nondisabled? Do you require a physical examination?*

The statement in our testimony to which you refer relates to provisions in private pension plans which provide replacement for income loss due to disability retirement.

This type of benefit is designed to provide an employee who has become disabled (generally in the sense of being totally and permanently disabled) with an income which reasonably meets the needs of the disabled worker and his family during continuation of disability. In most cases if disability continues until the worker reaches retirement age (generally age 65), the regular retirement benefits provided in the pension plan provide income from that time on. Provision for reimbursement for the expenses of medical care while disabled are made through other mechanisms, e.g., group hospital and surgical, or major medical insurance. As indicated in our response to question 3, major medical policies and other health care coverages are ordinarily sold to groups and individuals in active employment, or in good health, to provide protection prior to becoming sick or disabled. Companies do not ordinarily issue policies to persons who are then totally and permanently disabled. As a consequence, the question of an extra premium or a physical examination has no application.

Question 10. *You refer on page 8 of your testimony to the need to allow "initiative and experimentation" in private health insurance. What experimentation have you carried on in getting these severely disabled people protected?*

We have indicated previously, that we have made substantial progress in our efforts to provide health insurance that will be both comprehensive in coverage and at the same time within the economic means of the majority of our population. We reiterate that our purpose is to provide in advance for these misfortunes, by making coverage available to those who are active. Through this mechanism, benefits will be available when an insured person becomes disabled.

We have mentioned the 51 million people who had major medical expense insurance at the end of 1965. Initially, this broad coverage insurance was restricted in scope of benefits and provided maximum reimbursement of only

\$5,000 to \$10,000. As our companies gained experience, they experimented with extensions of coverage, higher benefit limits, removal of restrictions and exclusions, and continuance of the coverage during periods of long-term disability. Today, under major medical expense and comprehensive medical expense coverage aggregate reimbursement limits of \$40,000 are not unknown; \$20,000 is common. It is important to note that this type of policy offers such out-of-hospital benefits as prescribed drugs, private duty nursing, and nursing home care—all of which are likely needs of the disabled.

Question 11. If studies showed that the disabled are even worse off than the aged in terms of the income and extent of private health insurance protection, would your association then be in favor of extending Medicare to them?

We noted in our testimony that there is no doubt that some of the disabled need government assistance. In the absence of current, comprehensive data, it is our belief that the kind and extent of assistance which these people need would not be best served by the benefits contained in Medicare (Title XVIII). This was a program designed specifically for persons at ages 65 and over. The benefits are oriented toward acute hospitalization and related services. They do not provide sufficient rehabilitative benefits and no long term, custodial type care which are likely to be required by persons disabled six months or longer. We believe that a current study of the disabled would demonstrate these different needs. To the extent that such proves to be the case, particularly in situations involving incomes at near indigent levels, Title XIX would provide a more satisfactory solution to the problem than would Title XVIII.

If there is any further information which you or your Committee desire on this subject, we will attempt to supply it.

Sincerely,

ROBERT R. NEAL, *General Manager.*

REPORT ON NEW HEALTH INSURANCE POLICIES OF INSURANCE COMPANIES

**AVAILABLE TO THOSE 65 AND OVER —
AS OF JULY 1, 1966**

HEALTH INSURANCE INSTITUTE

THE MEDICARE PROGRAM*

The Medicare program, which helps to pay hospital and medical expenses of those 65 years of age and over became effective July 1, 1966. The program was established through the 1965 Social Security Amendments passed by Congress and signed into law in July, 1965.

The Medicare program is divided into two parts: **Part A and Part B.**

Part A provides benefits toward the costs of hospitalization, outpatient diagnostic services and post-hospital care in an extended care facility or in the patient's home. This part of the program is available to nearly all those 65 and over whether or not they are eligible for social security cash benefits.

Benefits for services in an extended care facility under the Medicare program become effective January 1, 1967.

Part B provides benefits toward paying physicians' and surgeons' services. It also helps pay for home health services and a variety of other medical services and supplies, furnished both in and out of the hospital. This part is voluntary and persons over 65 must enroll to have this protection. The cost for Part B of the program is presently \$6.00 a month — \$3.00 paid by the enrolled person; and \$3.00 paid by the Federal Government from general revenues.

For an outline of the benefits provided by Parts A and B of the Medicare program, see Appendix A of this booklet.

*More information on Medicare can be obtained from your local social security office and Your Medicare Handbook.

NEW INSURANCE COMPANY PLANS

The plans outlined in this booklet present a wide choice of health insurance protection offered by insurance companies to people 65 years of age and over. All the plans are available to new applicants. This report was compiled as of July 1, 1966 — the effective date of the Medicare program.

The purpose of this booklet is to provide information about these new insurance company programs for those 65 and over and how these plans can be effectively used with the Medicare program. Knowing what benefits are provided by the Medicare program and the benefits available under insurance company plans is essential in this regard. Both the Medicare program's provisions outlined in Appendix A and those of insurance company plans outlined in Sections I and II should be studied carefully.

This report should not be considered all-inclusive, but rather an indication of the extent, as of July 1, 1966, to which insurance companies are making available health insurance plans for those 65 and over.

SECTION I

PLANS ESPECIALLY DESIGNED FOR PERSONS WITH MEDICARE BENEFITS

A. Hospital-Patient Income Plans

These plans pay the insured person a stated dollar allowance on a daily, weekly, or monthly basis while in the hospital. This cash benefit amount may be used to pay for hospital services not covered by Medicare or to take care of the many personal expenses of a hospitalization.

Many of these plans continue their benefits up to one year of hospitalization and thus go beyond the 90 day "spell of illness" period covered by the Medicare program. Also, many plans increase the amount of their benefit allowance once an initial 90 day period of hospital care has been exhausted.

In addition to dollar allowances for periods of hospital care, a number of plans in this category provide cash benefits for nursing or convalescent home confinements. Some plans also provide a listed dollar benefit toward the cost of operations. A number of

plans provide dollar benefits toward the cost of physician visits while the insured person is in the hospital.

Other benefits provided by some of these plans include private duty nursing, out-patient emergency accident care, and a cash sum in the event of accidental death. These benefits are sometimes included within the policy itself, or can be added to the policy at additional cost.

Some of these insurance company plans are guaranteed renewable for each individual. Others are guaranteed for the individual as long as they are renewable for all residents of a particular state. Still other plans are renewable at the option of the insurance company.

The majority of these plans accept new applicants to age 70 and beyond.

COMPANY	HOSPITAL BENEFIT	DURATION	OTHER BENEFITS	ENTRANCE AGE UP TO:	RENEWAL
The American Hospital & Life Insurance Co. P. O. Box 2341 San Antonio, Texas 78206	\$100.00 a week	52 weeks		100	Renewable At Option of Company — To No Age Limit
American Republic Insurance Co. P. O. Box 10 Des Moines, Iowa 50301	\$7.50 a day to \$22.50 a day	365 days		No Limit	Guaranteed Renewable — For Life
Atlas Life Insurance Company Box 1919 Tulsa, Oklahoma 74102	TO: \$300.00 a month	5 months		70	Renewable At Option of Company — To No Age Limit

(Continued on next page)

COMPANY	HOSPITAL BENEFIT	DURATION	OTHER BENEFITS	ENTRANCE AGE UP TO:	RENEWAL
Central States Health & Life Insurance Co. of Omaha 504 South 18th Street Omaha, Nebraska 68102	\$5.00 a day — 1st day — 60th day \$25.00 a day — 61st day — 365th day	365 days		64-80	Guaranteed Renewable — For Life
Coastal States Life Insurance Co. 1459 Peachtree Street, N.E. (P. O. Box 7037) Atlanta, Ga. 30309	\$5.00 a day — 1st day — 30th day \$10.00 a day — 31st day — 60th day \$15.00 a day — 61st day — 240th day or \$10.00 a day — 1st day — 30th day \$15.00 a day — 31st day — 60th day \$20.00 a day — 61st day — 240th day	240 days		70+	Continuable — Unless terminated on class basis
Columbus Mutual Life Insurance Co. 303 E. Broad Street Columbus, Ohio 43215	\$150.00 a month to \$450.00 a month	26 weeks	Convalescent Home Benefits* *Optional at extra premium.	80	Renewable At Option of Company — To No Age Limit
Combined Insurance Co. of America 5050 Broadway Chicago, Ill. 60640	\$100.00 a month to \$500.00 a month	12 months	Return of premium — up to 10 years in event of accidental death.	No Limit	Renewable At Option of Company — To No Age Limit
Commercial State Life Insurance Co. 3570 Lindell Blvd. St. Louis, Mo.	\$40.00 — 1st week + \$100.00 a week — 2nd week (6th day) — 14th week.	90 days	Medical Charges: \$50.00 1st Doctor Bill + 20% of expenses to \$150.00. Home Care — \$25.00 a week equal to days of hospitalization.	63 and over	Renewable At Option of Company — To No Age Limit
Commercial Travelers Mutual Accident Association 70 Genesee Street Utica, New York 13502	\$50.00 a week \$100.00 a week	52 weeks		No Limit	Continuable — Unless terminated for all residents of state.

(Continued on next page)

COMPANY	HOSPITAL BENEFIT	DURATION	OTHER BENEFITS	ENTRANCE AGE UP TO:	RENEWAL
Continental Casualty Company 310 South Michigan Avenue Chicago, Ill. 60604	\$40.00 Medicare Deductible + \$5.00 a day — 1st day — 60th day \$10.00 a day — 61st day — 90th day or \$15.00 a day — 61st day — 90th day \$50.00 a day — 91st day — 365th day	365 days	Extended Care Facility: \$5.00 — \$10.00 a day Private Nurse: \$16.00 a day at \$2.00 an hour Surgery, Anesthetist, Physician treatment — 20% of expenses. Accidental Death — \$1,000.00 Out-patient care — \$100.00*	No Limit	Continuable — Unless terminated for all residents of state.
	\$50.00 a week — 1st week — 10th week \$125.00 a week — 11th week — 15th week \$200.00 a week — 16th week — 52nd week or \$100.00 a week — 1st week — 10th week \$175.00 a week — 11th week — 15th week \$250.00 a week — 16th week — 52nd week \$100.00 a month \$250.00 a month	52 weeks	Out-patient care — \$100.00* *Optional at extra premium.	No Limit	Continuable — Unless terminated for all residents of state.
		12 months		No Limit	Continuable — Unless terminated for all residents of state.
		52 weeks		No Limit	Continuable — Unless terminated for all residents of state.
		52 weeks	Accident Out-Patient Treatment — No Limit Doctor allowance accident emergency — \$25.00 Medicare Hospital Deductible — \$40.00*	75	Guaranteed Renewable
		362 days	Surgical Schedule — \$300.00* Medicare Hospital Deductible — \$40.00*	75	Guaranteed Renewable
	\$5.00 a day — 4th day — 60th day \$10.00 a day — 61st day — 90th day \$20.00 a day — 91st day — 365th day		Surgical Schedule — \$300.00* *Optional at extra premium.		
		180 days	Nursing Home Benefit — 30 days	85	Guaranteed Renewable — For Life
Country Life Insurance Co. P. O. Box 575 Bloomington, Ill. 61701	\$50.00 a week to \$200.00 a week	52 weeks		No Limit	Guaranteed Renewable — For Life
Craftsman Life Insurance Co. 851 Boylston Street Boston, Mass. 02116	\$50.00 a week to \$200.00 a week	52 weeks		No Limit	Guaranteed Renewable
Farm Family Life Insurance Co. -Box 656 Albany, New York	\$10.00 a day	180 days		85	Guaranteed Renewable — For Life

COMPANY	HOSPITAL BENEFIT	DURATION	OTHER BENEFITS	ENTRANCE AGE UP TO:	RENEWAL
Federal Life & Casualty Co. 78 W. Michigan Avenue Battie Creek, Michigan 49016	\$70.00 a week \$105.00 a week	52 weeks	Re recuperative Benefit — \$35.00 a week up to length of hospitalization. Surgical Schedule — \$200.00	65 and over	Continuable — Unless terminated for all residents of state.
Federal Life Insurance Co. (Mutual) 6100 North Cicero Avenue Chicago, Ill. 60646	\$37.50 a week to \$75.00 a week	52 weeks	Nursing Home: ¼ weekly hospital benefit up to length of hospitalization. Double hospital benefit — after 13 weeks.*	65 and over	Guaranteed Renewable — For Life
*Optional at extra premium.					
First National Casualty Co. 104 South Main Street Fond du Lac, Wisconsin	\$100.00 a month to \$500.00 a month	12 months	Return of premium — Up to 10 years in event of accidental death.	No Limit	Renewable At Option of Company — To No Age Limit
Girard Life Insurance Co. of America 250 B Exchange Park North Dallas, Texas	\$50.00 a week \$100.00 a week.	52 weeks + additional 10 weeks each year renewed up to 5 years.		75	Guaranteed Renewable — For Life
Globe Life and Accident Ins. Co. Globe Life Building Oklahoma City, Oklahoma	\$40.00 Medicare Deductible + \$10.00 a day — 61st day — 90th day \$20.00 a day — 91st day — 355th day	Medicare Deductible (First 60 days) + 305 days	Registered Nurse — 30 days Accidental Death — \$1,000.00 Surgeon and Doctor — First \$50.00 of charges + 20% of next \$500.00* Hospital Benefit — \$7.50 a day 1st day — 90th day*	81	Guaranteed Renewable — For Life
	\$10.00 a day — 61st day — 90th day or \$20.00 a day — 91st day — 355th day or \$30.00 a day — 91st day — 355th day	305 days	Accidental Death — \$1,000.00	81	Guaranteed Renewable — For Life
	\$40.00 a day — 91st day — 355th day	305 days	Accidental Death — \$1,000.00		
	\$50.00 a week \$75.00 a week \$100.00 a week	50 weeks	Accidental Death — \$2,500.00* Surgical Schedule*	81	Guaranteed Renewable — For Life
*Optional at extra premium.					
MEDICAL/SURGICAL PLAN.					
\$200.00 policy year maximum — Surgery; Doctor visits home — \$6 — office — \$5 — hospital — \$3; electrocardiogram; X-ray and metabolism tests.					

(Continued on next page)

COMPANY	HOSPITAL BENEFIT	DURATION	OTHER BENEFITS	ENTRANCE AGE UP TO:	RENEWAL
Great American Reserve P. O. Box 380 Dallas, Texas 75221	\$300.00 a month \$450.00 a month	90 days		60-80	Renewable At Option of Company — To No Age Limit
Hartford Accident & Indemnity Co. 690 Asylum Avenue Hartford, Connecticut 06115	\$10.00 a day — 1st day — 60th day \$15.00 a day — 61st day — 180th day	180 days	Nursing Home — \$5.00 a day — 21st day — 100th day	No Limit	Renewable At Option of Company — To No Age Limit
Hartford Life Insurance Co. 690 Asylum Avenue Hartford, Connecticut 06115	\$10.00 a day — 1st day — 60th day \$15.00 a day — 61st day — 180th day	180 days	Nursing Home — \$5.00 a day — 21st day — 100th day	No Limit	Renewable At Option of Company — To No Age Limit
Horace Mann Mutual Insurance Co. 216 East Monroe Street Springfield, Illinois 62701	\$10.00 a day from 8th day \$15.00 a day from 8th day	365 days	Nursing Home: \$5.00 a day for 60 days \$7.50 a day for 60 days	No Limit	Continuable — Unless terminated for all residents of state.
Illinois Mutual Life and Casualty Co. 411 Liberty Street Peoria, Illinois 61602	\$8.00 a day* to \$32.00 a day* *Benefits reduced 50% for period of eligibility for same benefits under Medicare.	365 days	Nursing Home: \$8.00 a day — 180 days** to \$16.00 a day — 180 days** Accidental Medical Expense to \$50.00** **Optional at extra premium.	79	Guaranteed Renewable — For Life
Independence Life and Accident Insurance Company 137 West Walnut Street Louisville, Kentucky 40202	\$70.00 a week \$105.00 a week	52 weeks* *13 weeks Mental Illness		80	Continuable — Unless terminated for all residents of state.
Inter-Ocean Insurance Co. 2800 Victory Parkway Cincinnati, Ohio 45206	\$100.00 a week	13 weeks* *Increased with accumulation of added benefit weeks.		No Limit	Continuable — Unless terminated for all residents of state.
Life Insurance Co. of Georgia P. O. Box 6207, Station H Atlanta, Ga. 30308	\$10.00 a day	90 days		No Limit	Guaranteed Renewable — For Life

COMPANY	HOSPITAL BENEFIT	DURATION	OTHER BENEFITS	ENTRANCE AGE UP TO:	RENEWAL
Lumbermens Mutual Casualty Co. Mutual Insurance Building 4750 North Sheridan Road Chicago, Illinois 60640	\$250.00 a month to \$500.00 a month	12 months		No Limit	Guaranteed Renewable — For Life
The Midwest Life Insurance Co. 500 South 18th Street Lincoln, Nebraska 68509	\$50.00 a week \$75.00 a week	26 weeks		No Limit	Renewable At Option of Company — To No Age Limit
Ministers Life & Casualty 3100 West Lake Street Minneapolis, Minnesota 55416	\$10.00 a day	No Limit		No Limit* *No health requirement.	Guaranteed Renewable
Minnesota Protective Association 730 Hennepin Avenue Northwestern Federal Bldg. Minneapolis, Minnesota 55403	\$40.00 — 60th day — 90th day \$10.00 a day — 91st day — thereafter* or \$25.00 a day — 91st day — thereafter*	Determined by maximum.*	\$500.00 — Surgical Schedule	No Limit	Renewable At Option of Company — To No Age Limit
	*Maximum \$500.00 each confinement. \$200.00 a month to \$1,000 a month	12 months		No Limit	Renewable At Option of Company — To No Age Limit
Monarch Life Insurance Co. 1250 State Street Springfield, Mass. 01101	\$150.00 a month to \$1,200.00 a month	6 months	Accidental Death and Dismemberment Benefit* *Optional at extra premium.	No Limit	Guaranteed Renewable
Mutual of Omaha Farnam at 33rd Street Omaha, Nebraska 68131	\$50.00 a week \$100.00 a week \$150.00 a week	26 weeks	Surgical Schedule — \$225.00* Double hospital benefit after 8th week hospitalization.* Triple hospital benefit after 13th week hospitalization (not available with \$150. per week plan)* *Optional at extra premium.	No Limit* *Irrespec- tive of state of health.	Continuable — Unless terminated for all residents of state.
Mutual Security Life Insurance Co. 3000 East U. S. 30 By-Pass Fort Wayne, Indiana 46805	\$300.00 a month	12 months	Emergency out-patient accident — \$30.00 Accidental death benefit — \$300.00 Surgical Schedule — \$300.00* *Optional at extra premium.	No Limit	Guaranteed Renewable — For Life

(Continued on next page)

COMPANY	HOSPITAL BENEFIT	DURATION	OTHER BENEFITS	ENTRANCE AGE UP TO:	RENEWAL
National Casualty Company 1100 Griswold Bldg. Detroit, Michigan 48226	\$50.00 a week \$100.00 a week	52 weeks		No Limit	Renewable At Option of Company — To No Age Limit
National Fidelity Life Ins. Co. 1002 Walnut Kansas City, Missouri 64106	\$100.00 a month — 1st day — 60th day \$400.00 a month — 61st day — 90th day \$600.00 a month — 91st day — 365th day	365 days	Medicare Deductible — \$40.00	80	Guaranteed Renewable — For Life
National Home Life Assurance Co. 4242 Lindell Blvd. St. Louis, Missouri 63108	\$50.00 a week to \$100.00 a week	20 weeks		100	Guaranteed Renewable — For Life
National Travelers Life Company 820 Keosauqua Way Des Moines, Iowa 50308	\$200.00 a month — 1st month & 2nd month \$400.00 a month — 3rd month & 4th month \$600.00 a month — 5th month & 6th month	6 months	Surgical Schedule — \$150.00	64-79	Continuable — Unless terminated for all residents of state.
Nationwide Mutual Insurance Co. 246 North High Street Columbus, Ohio 43216	\$360.00 a month or \$500.00 a month \$210.00 a month or \$350.00 a month \$150.00 a month or \$250.00 a month	180 days 180 days 180 days		65-69 70-79 80 and over	Continuable — Unless terminated for all policyholders of same policy form. Continuable — Unless terminated for all policyholders of same policy form. Continuable — Unless terminated for all policyholders of same policy form.
Nebraska National Life Ins. Co. 1222 "P" Street Lincoln, Nebraska 68501	\$4.00 a day to \$10.00 a day	365 days		No Limit	Renewable At Option of Company — To No Age Limit
North American Co. for Life, Accident & Health Insurance 209 South LaSalle Street Chicago, Illinois 60604	\$50.00 a week to \$100.00 a week \$50.00 a week to \$200.00 a week	52 weeks 52 weeks		75 75	Guaranteed Renewable — For Life Renewable At Option of Company — To No Age Limit

COMPANY	HOSPITAL BENEFIT	DURATION	OTHER BENEFITS	ENTRANCE AGE UP TO:	RENEWAL
North American Life Insurance Co. of Chicago 35 East Wacker Drive Chicago, Ill. 60601	\$10.00 a day— from 61st day to max. 270 days.	270 days	Surgical Schedule — \$200.00	80	Renewable At Option of Company — To No Age Limit
Occidental Life Insurance Co. of California 12th Street at Hill and Olive Box 201 Terminal Annex Los Angeles, Calif. 90054	\$10.00 a day	180 days		61-89	Continuable — Unless terminated for all policyholders of same policy form.
Old Equity Life Insurance Company 811 Chicago Avenue Evanston, Ill. 60202	\$200.00 a month \$400.00 a month	12 months	Home Care — \$100.00 a month for 3 months but not to exceed hospitalization stay. Surgical Schedule — \$600.00; \$300.00*	No Limit	Guaranteed Renewable — For Life
Provident Life and Accident Insurance Company Fountain Square Chattanooga, Tennessee 37402	\$5.00 a day to \$10.00 a day	365 days	Surgical Schedule — \$200.00*	75	Guaranteed Renewable — For Life
Reliance Insurance Company 4 Penn Center Plaza Philadelphia, Penna. 19103	\$5.00 a day \$10.00 a day	150 days	*Optional at extra premium.	No Limit	Renewable At Option of Company — To No Age Limit
Reliance Standard Life Ins. Co. 4 Penn Center Plaza Philadelphia, Penna. 19103	\$5.00 a day \$10.00 a day	150 days		No Limit	Renewable At Option of Company — To No Age Limit
St. Paul Hospital & Casualty Co. 1955 University Avenue St. Paul, Minnesota 55104	\$40.00 Medicare Deductible + \$10.00 a day — 60th day — 90th day \$25.00 a day — 91st day thereafter* 80% hospital ancillary charges. *Maximum benefit \$10,000. \$50.00 a week to \$100.00 a week	*Determined by max. of \$10,000. 26 weeks	Extended care facility: \$5.00 a day — 21st day — 100th day Out-patient benefit: \$20.00 + 20% thereafter for 20 days. **Optional at extra premium.	No Limit*** ***Irrespective of state of health.	Renewable At Option of Company — To No Age Limit
Teachers Protective Mutual Life Insurance Company 116-118 N. Prince Street Lancaster, Pa.	\$50.00 a week to \$200.00 a week	52 weeks		79	Guaranteed Renewable — For Life

(Continued on next page)

COMPANY	HOSPITAL BENEFIT	DURATION	OTHER BENEFITS	ENTRANCE AGE UP TO:	RENEWAL
Time Insurance Company 735 North 5th Street Milwaukee, Wisconsin	\$100.00 a month to \$300.00 a month \$5.00 a day \$10.00 a day	12 months 365 days	Nursing Home—60 days following hospital confinement.	70 No Age Limit	Guaranteed Renewable— For Life Renewable At Option of Company—To No Age Limit
The Travelers Insurance Company One Tower Square Hartford, Conn. 06115	\$300.00 a month \$450.00 a month	12 months	Nursing Home—\$150.00 a month—2 months duration, if confined within 14 days, after minimum 3 days hospitalization.	65 and over	Renewable At Option of Company—Regardless of change in health.
The United States Life Insurance Co. in the City of New York 125 Maiden Lane New York, New York 10038	\$10.00 a day—1st day—60th day \$20.00 a day—61st day— 365th day	365 days	Nursing Home—\$5.00 a day 21st day to 100th day Out-patient diagnostic—\$20.00	64 and over	Renewable At Option of Company—To No Age Limit
Washington National Insurance Co. 1630 Chicago Avenue Evanston, Ill. 60201	\$10.00 a day—61st day—90th day \$25.00 a day—91st day— 180th day 80% of hospital miscellaneous expenses to maximum \$1,000.00— 91st day to 180th day.	120 days	Extended Care Facility: \$5.00 a day—21st day to 100th day. Private Duty Nursing (R.N.—3 Shifts)—\$25.00 a day 1st day to 180th day.	No Limit	Guaranteed Renewable— For Life
The Western Casualty & Surety Co. 14 East First Street Fort Scott, Kansas 66701	\$10.00 a week to \$150.00 a week	52 weeks		74	Renewable At Option of Company—To No Age Limit
Wisconsin National Life Insurance Company P. O. Box 740 (220 Washington Avenue) Oshkosh, Wisconsin 54901	\$10.00 a day—60th day—90th day \$25.00 a day—91st day— thereafter* *To max. per confinement: \$3,000.00	Determined by max.*		No Limit	Continuable—Unless terminated on a class basis.
Woodmen Accident and Life Co. 1526 K Street Lincoln, Nebraska 68508	\$5.00 a day to \$20.00 a day	100 days or 365 days		No Limit	Guaranteed Renewable— For Life
World Insurance Company 203 South 18th Street Omaha, Nebraska 68102	\$100.00 a month to \$400.00 a month	12 months	Surgical Schedule—\$300.00* *Optional at extra premium.	80	Guaranteed Renewable— For Life

B. Medical Expense Reimbursement Plans (while in-or-out of the hospital)

These plans can provide a stated dollar amount, daily or weekly, to the insured person while in the hospital or can be arranged to pay a percentage of expenses for services during the hospital stay. Benefits are provided to pay for only charges not covered by Medicare. In general, benefit periods go beyond the 90-day hospital period allowed by Medicare and continue to one year or more, or until a stated maximum amount of benefits has been paid, say \$5,000 or \$10,000.

Most of these plans set no age limit for new applicants. They are commonly offered on a guaranteed renewable basis for individuals. Others are renewable at the option of the insurance company.

These plans provide benefits toward the cost of such services as private duty nursing and those prescription drugs not covered

COMPANY	HOSPITAL BENEFIT	DURATION	DEDUCT.	SURG. & PHYSICIAN	NURSE	NURSING HOME	DRUGS	OTHER BENEFITS	ENTRANCE AGE UP TO:	RENEWAL
MetLife and Casualty Company 151 Farmington Ave. Hartford, Conn. 06115	80% of charges not covered by Medicare — up to: \$12.00 a day — 1st day — 90th day \$32.00 a day — 91st day thereafter	Unlimited*	Medicare A & B + \$100.00* \$200.00* \$300.00*	80% of charges not covered by Medicare. 40% of charges out-of-hospital.	80% of charges in hospital. 80% of charges out-of-hospital.	80% charges not covered by Medicare — up to: \$4.00 a day — first 100 days. \$12.00 a day — thereafter*	80% out-of-hosp. prescription drugs*	80% emergency accident out-patient expense*	No Limit	Guaranteed Renewable — For Life
		*Subject to Lifetime Maximum: — \$10,000.00 \$15,000.00 \$20,000.00	*All cause determined by income.		80% of charges out-of-hosp. — 52 weeks*	*Subject to \$700.00 max. each disability — must follow within 14 days minimum 3 day hospitalization.	*Limited to 6 months following hospitalization.	*No mental coverage out-of-hospital.	No Limit*	Continuable — Unless terminated for all residents of state.
Continental Casualty Company 310 South Michigan Ave. Chicago, Ill. 60604	\$70.00 a week \$110.00 a week	52 weeks	None	80% of charges out-of-hosp. — 52 weeks*	Yearly max. \$2,500.00*		80% out-of-hosp. or out of nursing home max. — \$1,000 after hospitalization.	Recuperative benefit: \$70.00; \$110.00 on discharge after minimum 21 day hospitalization.	No Limit*	*Irrespective of state of health.
					*Optional at extra premium.					

(Continued on next page)

COMPANY	HOSPITAL BENEFIT	DURATION	DEDUCT.	SURG. & PHYSICIAN	NURSE	NURSING HOME	DRUGS	OTHER BENEFITS	ENTRANCE AGE UP TO:	RENEWAL
The Guardian Life Ins. Co. of America 201 Park Ave. South New York, N.Y. 10003	\$10.00 a day — 61st day — 90th day \$25.00 a day — next 365 days + 80% hospital ancillary charges to \$5,000. max.	395 days	Medicare A & B	80% of expenses above \$500.00	80% of charges first 10 days in hospital or first 10 days after opera- tion. + 80% charges up to 16 hours a day at home for 10 days.	\$5.00 a day — 21st day through 100th day* *Additional 365 days at \$15.00 a day — if totally paralyzed, unconscious or in coma as result of stroke or any other illness or injury.	80% out- of-hosp. prescrip- tion drugs for 6 months following hospitali- zation lasting at least 3 days.	\$15.00 hospital out- patient accident emergency.	No Limit	Continuable — while no medical or hospital insurance in force except Medicare.
Illinois Mutual Life and Casualty Company 411 Liberty Street Peoria, Ill. 61602	85% Covered Expenses* *Subject to max.: — \$8,000. — \$25.00 daily room limit. \$15,000 — \$30.00 daily room limit.	3 years	Medicare A & B + \$100.00	85% of covered expenses	85% charges in out-of- hospital.*	Up to \$15.00 a day — \$3,000. max. each accident or illness*	85% covered charges*	X-ray; radioactive laboratory; ambulance; medical supplies; rental ex- penses. Mental illness — \$3,000. max.*	79	Guaranteed Renewable — For Life
Inter-Ocean Ins. Co. 2600 Victory Parkway Cincinnati, Ohio 45206	80% hospital charges*	Determined by max.*	Medicare A & B or Medicare A & B + \$40.00 or \$50.00	80% of ex- penses*	80% charges in-out- hospital*	80% of charges — 180 days*	80% charges in-out-of hospital prescrip- tion drugs*	80% charges — emergency accident; out-patient treatment; medical appli- ances, etc.*	No Limit	Continuable — Unless terminated for all residents of state.
The National Masonic Provident Assn. 70 West Park Ave. Mansfield, Ohio 44901	80% covered charges* *Subject to maximum: — \$2,000.00	Determined by max.*	Medicare		80% charges in-hospital*	80% covered charges*		80% out- patient treatment*	No Limit	Renewable at Option of Company — To No Age Limit

COMPANY	HOSPITAL BENEFIT	DURATION	DEDUCT.	SURG. & PHYSICIAN	NURSE	NURSING HOME	DRUGS	OTHER BENEFITS	ENTRANCE AGE UP TO:	RENEWAL
New York Life Ins. Co. 51 Madison Ave. New York, N.Y. 10010	\$10.00 a day — 1st day — 60th day \$20.00 a day — 61st day — 90th day \$30.00 a day — 91st day — 180th day + Up to \$1,000. hospital ancil- lary charges 91st day through 180th day.	180 days			\$45.00 a day — 20 days in- hospital. \$35.00 a day — 20 days in ex- tended care facility* \$15.00 a day — 101st day — 185th day* + \$500 miscel- laneous expenses 101st day through 185th day. Must follow with- in 14 days a minimum 3 day hospitalization.	\$5.00 a day — 1st day — 20th day* \$10.00 a day — 21st day — 100th* day \$15.00 a day — 101st day — 185th day* + \$500 miscel- laneous expenses 101st day through 185th day. Must follow with- in 14 days a minimum 3 day hospitalization.			80	Guaranteed Renewable — For Life
*Optional at extra premium.										
The Travelers Ins. Co. One Tower Square Hartford, Conn. 06115	\$5.00 a day — 1st day — 60th day \$15.00 a day — 61st day — 90th day \$25.00 a day — 91st day — 365th day + \$250.00 ancillary charges — 91st day — 365th day.	365 days		20% reason- able and customary fees to \$200.00 max. in any one calendar year.		\$5.00 a day — 21st day through 100th day.			No Limit	Renewable at Option of Company — Regardless of change in health.
The Union Labor Life Insurance Company 850 Third Avenue New York, N.Y. 10022	80% hospital minimum daily private room rate.* *Subject to life — time maximum: — \$5,000.00	Determined by max.*	Medicare A & B + \$50.00	80% covered expense*	80% charges in or out of hospital*	80% covered charges* Extended care facility must meet definition of hospital.	80% covered charges in or out of hosp.*	80% emergency accident, out- patient treat- ment; medical appliances*	No Limit**	Renewable at Option of Company **Irrespec- tive of — To No Age Limit health.

(Continued on next page)

SECTION II

PLANS DESIGNED FOR PERSONS WITH OR WITHOUT MEDICARE BENEFITS

A. Hospital-Surgical Expense Plans

These plans reimburse the insured person for the cost of hospital room-and-board charges and provide benefits for such other services performed in the hospital as laboratory work, X-rays, general nursing, dressings and medicines. These policies also make available benefits toward the cost of surgery. The amount of benefits provided are according to the particular surgical procedure performed.

Other benefits provided under typical policies are those for in-hospital doctor calls and private duty nursing while hospitalized.

If the insured person has Medicare benefits, some policies will not pay those charges covered by Medicare, thus excluding them. Other policies will consider Medicare payments as "other insur-

ance" and integrate their benefits with those of Medicare.

For those insured persons without Medicare benefits, these hospital-surgical expense policies will pay up to the limits of the benefits they provide.

Some of these insurance company plans are guaranteed renewable for each individual. Others are guaranteed for the individual as long as they are renewable for all residents of a particular state. Still other plans are renewable at the option of the insurance company.

The majority of these hospital-surgical expense plans accept new applicants to age 70 and beyond.

COMPANY	HOSPITAL ROOM & BOARD	DURATION	HOSPITAL ANCILLARY	SURG. SCHEDULE	OTHER BENEFITS	ENTRANCE AGE UP TO:	RENEWAL
American National Ins. Co. 6665 Delmar Blvd. St. Louis, Mo. 63130	\$5.00 a day to \$25.00 a day	500 days	\$50.00 to \$250.00 or \$75.00 to \$375.00 or 75% of \$100.00 to \$500.00 of charges + 100% next \$250.00 to \$1250.00 of charges	\$1,000.00	Convalescent home or home care: \$2.50 to \$12.50 a day following minimum 5 days hospitalization — 60 days. Mental illness — 50 days	66 and over	Guaranteed Renewable — For Life

MEDICARE CONSIDERED AS OTHER INSURANCE

COMPANY	HOSPITAL ROOM & BOARD	DURATION	HOSPITAL ANCILLARY	SURG. SCHEDULE	OTHER BENEFITS	ENTRANCE AGE UP TO:	RENEWAL
Atlas Life Insurance Co. 415 South Boston Tulsa, Oklahoma 74102	\$5.00 a day	30 days	\$6.00 a day	\$250.00	In-hospital doctor calls.	80	Renewable at Option of Company—To No Age Limit
Business Men's Assurance Co. of America BMA Tower Kansas City, Mo. 64141	\$10.00 a day	30 days			Accidental death* * Optional at extra premium.	80	Renewable at Option of Company—To No Age Limit
MEDICARE EXCLUSION							
Central States Health & Life Co. of Omaha Howard at 18th Omaha, Nebraska 68102	\$5.00 a day to \$25.00 a day	75 days	50% of 1st \$100.00 of charges up to max. \$2,000.00	\$350.00 \$455.00	Private nurse Ambulance Out-patient accident Physical exp.	80	Guaranteed Renewable — For Life
Lincoln Liberty Life Insurance Co. Box 1193 Lincoln, Nebraska 68501	\$7.00 a day* to \$25.00 a day*	120 days	\$150.00*	\$200.00 to \$500.00	In-hospital doctor visits Private nursing Emergency accident Dread disease benefit.	70	Guaranteed Renewable — For Life
*EXTRA HOSPITAL BENEFITS ON A CO-INSURANCE BASIS							
MEDICARE EXCLUSION							
Mutual Life Ins. Co. of America 2200 Walnut Street Philadelphia, Pa. 19103	\$5.00 a day to \$20.00 a day	6 months				85	Renewable at Option of Company — To No Age Limit
	\$6.00 a day to \$24.00 a day	Lifetime	Allocated or Unallocated	\$300.00	Private nurse for accident.	85	Guaranteed Renewable — For Life
	\$100.00 a week \$200.00 a week	Lifetime			Home recuperation — 50% weekly hospital benefit.	85	Guaranteed Renewable — For Life
MEDICARE CONSIDERED AS OTHER INSURANCE							

(Continued on next page)

COMPANY	HOSPITAL ROOM & BOARD	DURATION	HOSPITAL ANCILLARY	SURG. SCHEDULE	OTHER BENEFITS	ENTRANCE AGE UP TO:	RENEWAL
Mutual of Omaha 33rd and Farnam Sts. Omaha, Nebraska 68131	\$3.00 a day to \$40.00 a day	90 days	\$100.00 max. to \$1,000.00 max.* *Choice of six alternative ancillary benefits.	\$600.00* *\$375.00 New York	In-hospital doctor calls* Hospital out-patient treatments* Accidental death benefits* *Optional at extra premium.	74	Continuable — Unless policy changed for all residents of state.
IRRESPECTIVE OF MEDICARE							
Physicians Mutual Ins. Co. 115 South 42nd Street Omaha, Nebraska 68131	\$400.00 a month	60 days		\$225.00	Physical exam. — \$10.00 Home confinement* *Optional at extra premium.	No Limit*	Continuable — Unless terminated for all residents of state.
IRRESPECTIVE OF MEDICARE							
Southland Life Ins. Co. P. O. Box 2220 Dallas, Texas 75221	\$7.50 a day \$12.50 a day	70 days	\$90.00 \$150.00	\$150.00 \$250.00		85	Continuable — Unless terminated on class basis.
MEDICARE CONSIDERED AS OTHER INSURANCE							

B. Major Medical and Major Hospital Expense Plans

These plans are designed to provide benefits toward the expenses of a serious or prolonged illness or accident. They have high maximum benefits, ranging from \$5,000 to \$20,000. They have a "deductible amount" that must be paid before policy benefits begin. The "deductible" is a stated initial amount of covered medical expenses, say \$500, which must be paid before the policy's benefits take effect.

These major medical and major hospital policies also have a "co-insurance" feature whereby the insurance company pays 75-80% of covered expenses above the "deductible amount." Some policies have stated internal limits on the amount of benefits provided for certain medical expenses.

If the insured person has Medicare benefits to cover a portion

of his medical expenses, some policies will not consider such benefits toward satisfying the "deductible amount" required — thus excluding such expenses. Other policies will consider those benefits paid by Medicare as "other insurance" and thus credit them toward the required "deductible amount."

For those insured persons without Medicare benefits, these major medical and major hospital expense policies will pay up to the limits of the benefits they provide.

Such major medical and major hospital expense plans are made available on a guaranteed renewable basis for the lifetime of the insured person. The age for new applicants is up to 75 years and beyond.

COMPANY	MAX. BENEFIT	DEDUCTIBLE	CO-INSURANCE	ENTRANCE AGE UP TO:	RENEWAL
American National Ins. Co. 6865 Delmar Blvd. St. Louis, Mo. 63130	\$9,000.00* *PLAN DESIGNED ON A UNIT VALUE SCHEDULE OF \$9.00 A UNIT — MAXIMUM BENEFIT LISTED IS THE DOLLAR AMOUNT OF THE MAXIMUM NUMBER OF UNITS (1,000) AVAILABLE UNDER THE PLAN.	\$500.00	INTERNAL LIMITS CLASS A Expenses: Hospital room Surgeon fee Anesthetist fee Doctor fee Convalescent home — 90 days after minimum 5 day hospital stay. Class B Expenses: 25% Co-Insurance up to \$900.00 100% coverage thereafter. Hospital ancillary charges Local ambulance Private nurse (schedule limits) Physiotherapist (schedule limits) Diagnostic X-ray and laboratory Out-of-hospital drugs and medicines Other medical supplies and appliances Mental illness — In-hospital only to a Lifetime Maximum. Home Confinement — ½ hospital room allowance for 90 days following 5 day minimum hospitalization.	66 and over	Guaranteed Renewable — For Life

MEDICARE CONSIDERED AS OTHER INSURANCE

(Continued on next page)

COMPANY	MAX. BENEFIT	DEDUCTIBLE	CO-INSURANCE	ENTRANCE AGE UP TO:	RENEWAL
Girard Life Insurance Co. of America 250-B Exchange Park Dallas, Texas 75235	\$5,000.00*	\$500.00**	20%	75	Guaranteed Renewable — For Life
* IN-HOSPITAL BENEFIT ONLY					
** DEDUCTIBLE CAN BE AFFECTED BY EXISTING MEDICAL INSURANCE AND MAXIMUM BENEFIT INCREASED UP TO ADDITIONAL \$5,000 IF SUCH INSURANCE IS GREATER THAN PLAN'S DEDUCTIBLE.					
MEDICARE CONSIDERED AS OTHER INSURANCE					
Lincoln Liberty Life Ins. Co. Box 1193 Lincoln, Nebraska 68131	\$7,500.00 to \$10,000.00	\$500.00 & \$750.00	20% with \$25.00 internal limit on hospital room.	Age Limit Undetermined	Guaranteed Renewable — For Life
MEDICARE EXCLUSION					
The Midland Mutual Life Ins. Co. 250 East Broad Street Columbus, Ohio 43215	\$10,000.00 \$15,000.00 \$20,000.00	\$500; \$750 \$500; \$750; \$1,000 \$500; \$750; \$1,000	20%	No Age Limit	Guaranteed Renewable — For Life
MEDICARE CONSIDERED AS OTHER INSURANCE					

APPENDIX — A

MEDICARE

Part A — Hospital Insurance

HOSPITAL BENEFIT	DURATION	DEDUCTIBLE	EXTENDED CARE	HOME HEALTH CARE	OTHER BENEFITS	AGE
Semi-private room and board*			Semi-private room and board in nursing home or hospital convalescent area.	Hospital Home-Care Program Visiting Nurse Service Other Such Programs	1. Out-patient hospital diagnostic services — 80% of charges paid after \$20.00 deductible for each 20 day period of tests. 2. Treatment in mental hospital — 190 days lifetime maximum.	65 and over*
NO CHARGE AFTER DEDUCTIBLE	90 days	\$40.00	NO CHARGE*	NO CHARGE*		
1st day — 60th day			1st day — 20th day			
\$10.00 DAILY CHARGE			\$5.00 DAILY CHARGE	100 visits a year for part-time nursing physical therapy speech therapy occupational therapy medical appliances and supplies — except drugs (See Part — B — Other Benefits)		
61st day — 90th day			21st day — 100th day +			
Hospital ancillary services except.			Customary in-patient ancillary services including: Physical therapy Occupational therapy Speech therapy			
Radiologist** Anesthesiologist** Pathologist** Physiatrist**						
*Private room — if medically necessary; or at extra charge for patients comfort.			*After minimum 3-day hospitalization stay.	*After minimum 3-day hospital or extended care stay — additional benefit under supplementary medical insurance (See Part — B).		*Eligible most citizens and resident aliens with at least five years continuous residency in the United States.
**Services covered under supplementary medical insurance (see Part — B)						

CARE OR TREATMENT ONLY IN PARTICIPATING HOSPITAL OR APPROVED EXTENDED CARE FACILITY EXCEPT IN EMERGENCY

SERVICES NOT COVERED: 1. Physicians (See Part — B — Physician & Surgeon Benefit)

2. Routine physical examination.

3. Private duty nursing.

4. Out-of-hospital prescription drugs (See Part — B — Other Benefits)

5. General housekeeping services in patients home.

6. Personal comfort items — home, hospital or extended care facility.

ADDITIONAL INFORMATION ON MEDICARE MAY BE OBTAINED FROM YOUR
LOCAL SOCIAL SECURITY OFFICE OR YOUR MEDICARE HANDBOOK

(Continued on next page)

MEDICARE (Continued)

Part B — Supplementary Medical Insurance

Premium Charge: \$3.00 a month

PHYSICIAN & SURGEON SERVICES	DEDUCTIBLE	CO-INSURANCE	HOME HEALTH CARE	OTHER BENEFITS	AGE
80% REASONABLE CHARGES PAID Services Wherever Provided: Surgery Consultation Doctor Calls Home Hospital Nursing Home Office	\$50.00 a year	20%	80% REASONABLE CHARGES PAID: 100 home visits a year* of visiting nurse service of other approved agency for part-time nursing physical therapy speech therapy occupational therapy + medical equipment and supplies — except drugs. *Additional to Home Health Care Visits — Part A and without hospital or extended care stay.	80% REASONABLE CHARGES PAID: 1. Diagnostic tests — X-ray, laboratory and other services, 2. X-ray, radium and radio- active isotope therapy, 3. Surgical dressings, splints, casts, 4. Braces, artificial limbs and eyes, 5. Rental medical equipment — e.g. iron lung, 6. Prosthetic devices, 7. Ambulance service, 8. Other medical items and services — e.g. out-of- hospital drugs and medicine prescribed and administered by doctor. *Eligible: all citizens and resident aliens with at least five years con- tinuous resi- dency in the United States.	65 and over*

SERVICES

NOT COVERED:

1. Routine physical check-ups.
2. Routine dental care and dentures.
3. Full-time private nursing.
4. Self-administered prescription drugs.
5. Hearing aids; orthopedic shoes; eye-
glasses or contact lens for refractive
correction.
6. General housekeeping services.
7. Personal comfort items.

ADDITIONAL INFORMATION ON MEDICARE MAY BE OBTAINED FROM YOUR
LOCAL SOCIAL SECURITY OFFICE OR YOUR MEDICARE HANDBOOK

The preceding report does not indicate the many group health insurance programs covering persons over 65 who were formerly employed and now retired. Such group programs provide retirees with supplemental health insurance to the existing Medicare program. These group health insurance programs usually provide benefits covering the catastrophic or prolonged illness or accident for the retired worker.

This report also does not cover the health insurance plans held by individuals from their earlier years, who have retired or who are about to retire. Such insured persons, holding guaranteed lifetime protection, can elect to keep their health insurance programs intact or, many times, have the option of converting their policies into a complementary form to the Medicare program.

The CHAIRMAN. Mr. Ralph S. Haskins. Members of the committee, Mr. Haskins is a friend of mine from Little Rock, Ark. He is employed by the Veterans' Administration in one of our very fine hospital facilities. We appreciate very much having Mr. Haskins with us as president of the American Medical Technologists. You are accompanied, Mr. Haskins by—

STATEMENT OF RALPH S. HASKINS, NATIONAL PRESIDENT, AMERICAN MEDICAL TECHNOLOGISTS; ACCOMPANIED BY WORTH YODER AND BILLY DWIGHT PERRY

Mr. HASKINS. Mr. Worth Yoder, AMT general counsel, and Mr. Billy Dwight Perry, our special counsel.

The CHAIRMAN. We are glad to have you gentlemen with us and you may have a seat, if you will, Mr. Haskins. You are recognized, sir. If you wish to omit any part of your statement, do it with the knowledge that the entire statement will appear in the record.

Mr. HASKINS. Thank you, Mr. Chairman. We have prepared a statement for the record and I will try to summarize our statement.

I am national president of American Medical Technologists, an independent registry of over 10,000 registrants. Present requirements for registration in American Medical Technologists includes 2 years of formal training, consisting of at least 1 year at an approved technical school, or an Armed Forces school, and at least 6 months of internship in a clinical laboratory setting, plus an examination. That our people are well qualified is indicated by the fact that they work as technologists in Veterans' Administration hospitals, in military hospitals, including Bethesda Naval Hospital and Walter Reed Army Hospital, in independent laboratories, research laboratories, and other sites throughout the country that conduct medical testing.

It is not my purpose this morning to make any statement against H.R. 5710, but rather to point out a serious deficiency in the administration of the Medicare Act which disqualifies many competent technologists, thus aggravating the serious shortage of qualified laboratory personnel that presently exists in this country. This deficiency results from the Secretary's unreasonable, unnecessary, and discriminatory regulations implementing the Medicare Act which govern independent laboratories. I would like to speak to you today about these regulations.

Actually, there are two sets of regulations dealing with medical laboratories: one for hospitals and another for independent laboratories. So far as technologists are concerned, the hospital regulations state simply that there must be a sufficient number of technologists to perform properly and proficiently the tests that are requested. There is a stated preference for technologists registered with the ASCP, which we believe is unwarranted, but this does not require the exclusion of qualified technologists from their jobs. These regulations set high standards for laboratory directors—they must be either a physician or the holder of a doctorate degree—and they make the selection of qualified lower echelon laboratory personnel the responsibility of that director. This is where we believe that responsibility belongs.

The regulations for independent laboratories, on the other hand, set detailed educational and training standards for all laboratory personnel. We are not objecting to the high standards these regulations set

for directors, but we do strongly object to the unrealistic and repressive qualifications which technologists must meet in order to work in the independent laboratories. They go far beyond the hospital laboratory regulations; and if allowed to stand these regulations will totally disqualify thousands of competent medical technologists, including those registered by AMT, who under the other regulations are fully qualified to work as technologists in hospital laboratories. I might add that AMT's registration requirements are not even recognized in the regulations as a training program for technicians, and yet the Secretary does recognize programs far inferior to our requirements.

To illustrate the effect of these regulations upon AMT registrants, as well as upon other technologists in the available work force, I would like to cite two examples.

A friend of mine, and an AMT registrant, is a laboratory supervisor in a State hospital. He has 27 years experience, 16 years as a lab supervisor. He was trained in both the vocational and in the Armed Forces schools. He has lectured on testing procedures at a famous State college. Yet, under the Secretary's regulations he can only work in an independent laboratory until 1971. After that, he is out.

The second example relates to technologists trained in 1-year Armed Forces schools. These are intensive laboratory procedure courses which are substantially similar to the requirements of AMT approved vocational schools. The caliber of their training is excellent. In fact, the Army's program of instruction for Letterman General Hospital states that its purpose is, and I quote, "to provide enlisted medical laboratory personnel with a working knowledge of medical laboratory technology so that they may become competent medical specialists and/or noncommissioned officers in charge of military medical laboratories."

These people are qualified to go to Vietnam and serve as a supervisor in an Army medical laboratory. They can hold the same position in military laboratories in the States. Yet, when they enter civilian life, they must be demoted to the grade of technician if they are to work in an independent laboratory.

We believe the Secretary has exceeded the authority granted by section 1861(s) (11) of the Medicare Act by issuing these regulations. That section gives him the power to set conditions necessary for the health and safety of medicare beneficiaries. In our opinion it is not necessary to have one standard for technologists in hospital labs and another more repressive set for personnel doing the same job in the independent laboratories. In fact, when the Secretary requested the statutory authority to prescribe conditions for independent laboratories, he told the Senate Finance Committee that the language he requested, and which was enacted without change, and I quote, "would assure that the (independent) laboratories meet the same standards essential to health and safety of beneficiaries as the hospital laboratories."

In summary, AMT is just as devoted to assuring that quality laboratory work is performed as is the Secretary of Health, Education, and Welfare. Such work can never be assured by setting unrealistic and arbitrary personnel qualifications. This is particularly true in a time of acute shortage of laboratory workers such as exists today.

The Secretary requested from Congress only the authority to set the same standards for independent laboratories as for hospital labora-

tories. We believe he should now be told to stay within that limit. If the Secretary will prepare reasonable regulations that do not disqualify competent personnel, we feel that would be sufficient. If he will not, we feel legislation will be necessary.

Mr. Chairman, if legislation does become necessary, AMT will be happy to submit a proposed amendment which we believe will remedy this situation.

On behalf of AMT and its over 10,000 registrants, I would like to thank this committee for allowing me to present this statement.

(The statement referred to follows:)

STATEMENT OF RALPH S. HASKINS, NATIONAL PRESIDENT, AMERICAN MEDICAL TECHNOLOGISTS

Mr. Chairman—members of the Committee. I am Ralph Haskins, National President of American Medical Technologists (AMT). On behalf of AMT and its registrants, I wish to thank you for the opportunity to present this statement before you today.

AMT is a National Registry of Medical Technologists, founded in 1939 and headquartered at 710 Higgins Road, Park Ridge, Illinois. Current registration is in excess of 10,000 persons, most of whom are presently working in laboratories throughout the country and are engaged in the testing of specimens to assist in the detection of human disorders. Our registrants include college and vocational school graduates, as well as several thousand veterans, most of whom were trained in Armed Forces schools of medical technology.

The standards for admission to the Registry are designed to assure that only qualified persons gain entry. Present minimum standards are formal training in an approved school and an internship for a total of two years, plus the passing of a difficult and comprehensive examination. The formal training must be taken either at a technical school approved by AMT and which requires a minimum of 1500 clock hours of instruction in all necessary laboratory subjects, an accredited college (60 semester hours), or an Armed Forces school of medical technology (1 year). For the committee's information, a more detailed statement of AMT's registration requirements is attached as Appendix 1. Also attached as Appendices 2 and 3, respectively, are the required courses which must be taken in a technical school and the Program of Instruction for Medical Laboratory Procedures (Advanced) Course at the Army's Letterman General Hospital, a typical Armed Forces school. I request that these appendices be inserted in the record following this statement.

One indicator of the adequacy of our requirements is the fact that accredited hospitals, pathologists, physicians, and independent laboratories throughout the country aggressively recruit technologists registered by AMT. A recent survey showed that some 22% of our registrants are currently employed as technologists or higher in accredited hospitals; some 30% are employed in pathologists' offices; some 20% are employed in physicians' offices; and some 10% are employed in independent laboratories. Many hospitals in the Washington area employ AMT registrants as technologists, including Bethesda Naval Hospital and Walter Reed Army Hospital.

My purpose in appearing before you today is not to oppose anything in H.R. 5710. Rather, I am here to call your attention to a serious and dangerous deficiency in the administration of the Medicare Act, a deficiency which has arbitrarily disqualified thousands of AMT and other technologists from their present positions in independent laboratories.

By regulations issued December 16, 1966 (31 Fed. Reg. 16137), the Secretary of Health, Education, and Welfare established standards of education and training for personnel working in independent laboratories which go far beyond the statutory limitation Section 1861(s)(11) of the Act imposes for such regulations, that is, conditions necessary for the health and safety of Medicare patients. This is apparent from the fact that these regulations exceed the limitations which the statute imposes for hospital laboratories and which the Secretary has adhered to in both his regulations governing hospitals and his proposed regulations governing nursing homes. The strange and unhappy result is that many technologists, both registered and not, qualify for employment in hospital laboratories, but not for employment in independent laboratories. This disparity is both incongruous and arbitrary. It is also dangerous since every responsible authority recognizes the existence of a critical shortage of laboratory personnel.

AMT did everything in its power to persuade HEW not to issue regulations having this result. Beginning in December, 1965, when AMT first learned that regulations were in the drafting stage, we offered the Department our complete cooperation in developing realistic standards that would not discriminate against any qualified competent laboratory worker. In the beginning our letters were not acknowledged. Often it was necessary to seek the good offices of Members of Congress even to obtain conferences with HEW officials. When conferences were held, we found those officials already predisposed against any conditions that did not strengthen the grip of the American Society of Clinical Pathologists (ASCP) on the nation's clinical laboratories. In fact, the regulations formally proposed on June 22, 1966 (31 Fed. Reg. 8668) disqualified all technologists not having a college degree or registered with the ASCP. The regulations finally adopted are not substantially improved, although the ASCP is no longer mentioned by name. Perhaps this deletion was prompted by the fact that the Department of Justice has filed an anti-trust action against The College of American Pathologists¹ in an effort to break the virtual monopoly which pathologists now have on laboratory testing.

We do not believe that Congress intended the Secretary to create a double standard for laboratory personnel: one for hospital laboratories and quite a different one for independent laboratories. Section 1861(e)(8) of the Medicare Act authorizes the Secretary to impose hospital conditions "necessary in the interest of the health and safety" of Medicare beneficiaries, but it also directs that these conditions may not be higher than those comparable requirements prescribed by the Joint Commission on Accreditation of Hospitals, a private accrediting agency. The power to prescribe necessary health and safety standards for independent laboratories is found in another paragraph of the Act (Section 1861(s)(11)) which was drafted at HEW and sent to the Senate Finance Committee after the Medicare Bill had passed the House.² In proposing this amendment, the Secretary told the Senate Committee that it—

"would assure that the [independent] laboratories meet the same standards essential to health and safety of beneficiaries as hospital laboratories."

In other words, the Secretary asked only for authority to impose "the same standards" on hospital and independent laboratories alike. Had he in fact done this in his regulation, I would not be here today. However, the Secretary did just the opposite: he decreed one set of standards for personnel in hospital laboratories and a radically more stringent and repressive set for those working in independent laboratories.

As far as hospitals are concerned, the regulations simply state that there must be a sufficient number of laboratory technologists to perform promptly and proficiently, the tests requested of the laboratory (31 Fed. Reg. at 13435). The proposed nursing home regulations simply adopt the hospital standards (31 Fed. Reg. at 7138). While these regulations do state a preference for technologists registered by the American Society of Clinical Pathologists (ASCP), a preference we do not believe warranted, this does, nevertheless, follow the Joint Commission's preference, while undesirable, is at least understandable: it is a private group showing preference for its own. Control of the Joint Commission is, after all, shared by the American Medical Association. The ASCP, an adjunct organization for pathologists, owns the ASCP registry. In fact, persons who become registered with ASCP must subscribe to a code which requires them to work only for MD's.³ The Secretary's adoption of this preference is another matter entirely, but that is not of real moment for my purpose here. The point is that the hospital regulations do not actually disqualify any competent technologists. Furthermore, it appears that most hospital laboratory directors place more

¹ United States v. The College of American Pathologists, Civil Action No. 66C 1253, U.S. Dist. Ct., N.D. Ill. (filed July 7, 1966).

² The Medicare Bill passed the House on April 8, 1965. The Secretary's proposal is contained in a letter dated May 17, 1965, and reprinted in Part 1 of the Senate Hearings beginning at page 494.

³ This code states:

I. A medical technologist will work at all times under the direction or supervision of a pathologist or other duly qualified and licensed doctor of medicine, such qualifications being determined on the basis of accepted medical ethics.

II. A medical technologist will not act as owner, coowner, adviser or employee, or by means of any subterfuge, participate in an arrangement whereby an individual not regularly licensed to practice medicine is enabled to own or operate a laboratory of clinical pathology.

Pamphlet, Registry of Medical Technologists of American Society of Clinical Pathologists, p. 11 (January 1966). Of the two registries, only AMT recognizes the obvious fact that it is not unethical for a medical technologist to work for a competent director who is not a medical doctor.

importance on personal competence than on registry affiliation. It even happens that a number of our vocational school and Armed Forces trained registrants teach in ASCP schools of medical technology.

The hospital regulations leave the qualifications of laboratory personnel below the grade of director to the laboratory director, and this, of course, is where the responsibility belongs. AMT has consistently argued that competent, well-trained, and ethical directors are the best possible assurances that laboratory testing will be accurately performed and reported. Such a director can and should be trusted to select properly qualified personnel and to limit each laboratory worker to those tasks within the limits of his individual competence, demonstrated to and known by that director. No amount of detailed regulation can ever assure the competence of a laboratory worker as well as can a qualified director having firsthand knowledge of his own employees. In the May 16, 1966, issue of *Hospitals* magazine, the Joint Commission expressed a very similar view by stating that the "responsibility for determining the training, experience, and competence of [technologists and technicians], registered or not" is in the hands of the pathologist in charge of the laboratory (*Accreditation Problems, Hospitals*, May 16, 1966, p. 42).

The Medicare regulations require that a director, whether of a hospital or of an independent laboratory, must be either a physician or the holder of an earned doctorate degree. There is one temporary exception for directors of independent laboratories, but it is carefully circumscribed by safeguards designed to assure not only that the director is competent, but that the laboratory itself is proficient in all the tests it performs.⁴ Furthermore, this exception expires in 1971. We consider these requirements to be at least adequate.

In marked contrast to the hospital regulations and the requirements of the Joint Commission, the Secretary's regulations for independent laboratories established detailed educational qualifications not only for directors and supervisors, but also for technologists and technicians. The minimum requirements for technologists are 3 years of study at an accredited college or university with specified semester hours in chemistry and biological studies, plus at least one year of training in a laboratory. The only exception is that until 1971 a person who has worked as a technologist within the past five years and has a total of ten years laboratory experience can qualify (31 Fed. Reg. 16141).

A graduate of a technical vocational school, regardless of his knowledge of scientific subjects and laboratory procedures, cannot qualify as a technologist under these regulations unless he has worked in a laboratory for ten years. And after 1971, he is absolutely barred, regardless of his years of experience. The absurdity of such a requirement is brought into sharp focus when applied to an AMT registrant trained in a technical school. These technologists have had intensive formal instructions in all relevant laboratory subjects, have interned in an approved laboratory, and have passed an examination which is failed by over 25% of all who take it. Upon graduation a number of hospitals are anxious to hire them as technologists. Yet these same technologists can never qualify as technologists in independent laboratories.

In our discussions with HEW we called their attention to an AMT registrant who is but one example of the unreasonableness of these regulations. He presently holds a State rating in a position as a laboratory supervisor and is working as a supervisor in a large State hospital. He has 27 years of experience, 16 of which are as a laboratory supervisor. He was trained in a vocational school and in the Armed Forces. He has been a teacher in an Armed Forces school of medical technology, and he has lectured on medical testing procedures at a famous college. Yet, with these qualifications, he absolutely cannot qualify as a technologist after 1971.

Furthermore, no graduate of an Armed Forces school can qualify as a technologist under these regulations unless he has ten years of experience. As in the case of technical school graduates, after 1971 no amount of experience is acceptable. This denies the quality of Army training. The Army Program of Instruction for Letterman General Hospital, approved by the Surgeon General of the Army, in May, 1965, states that its purpose is—

to provide enlisted medical personnel with a working knowledge of medical laboratory technology so that they may become competent technical spe-

⁴ To qualify under this exception the director must have held that position for at least one year in the past five. He must either have a master's degree with a major in a chemical, physical, or biological science, plus 4 years laboratory experience, or have a bachelor's degree with a similar major and 6 years of experience, or have passed a Public Health Service examination. Furthermore, the laboratory itself must have passed a State and/or State approved proficiency testing program covering all the specialties or subspecialties in which the laboratory performs tests (31 Fed. Reg. 16139-40).

cialists, and/or noncommissioned officers in charge of military medical laboratories.

This course, incidentally, is substantially similar to that required by AMT of its vocational school graduates, as can be seen from Appendices 2 and 3.

It is indeed strange that the Army considers a noncommissioned officer who graduates from this course qualified to be placed in charge of one of its laboratories, but the Secretary of HEW prohibits him from holding the less responsible position of technologist in a civilian laboratory. Unless such a man presently has at least six years experience, he can never be an independent laboratory technologist, since his experience will not total 10 years by 1971.

The regulations do state that an Armed Forces school graduate is competent to be a technician, but this is small consolation. A technician is defined in the regulations as one who "performs only those laboratory procedures which require limited technical skill and responsibility and a minimal exercise of independent judgment." (31 Fed. Reg. at 16141)

Discrimination among laboratory personnel based on place of employment (in independent laboratories instead of hospital laboratories) rather than on individual qualifications is arbitrary and inequitable on its face. It will also result in loss of jobs or demotions for vast numbers qualified as technologists who work in reputable independent laboratories throughout the country. It is no answer to say that they can find employment in hospitals. In many instances they would be uprooted from the towns where they live. In others, they would have to leave a job in which they were happily, successfully, and competently engaged. It could cause loss of seniority and pay. The point is that qualified technologists should not be required to suffer dismissal or demotion because of these arbitrary and unnecessary rules. If they are qualified to be in charge of military laboratories, they can be trusted as technologists in civilian laboratories. So also can those technologists who receive comparable schooling in civilian vocational schools.

Only last month the President told Congress, "The United States is facing a serious shortage of health manpower." According to figures furnished the House Commerce Committee last year, there is a present demand for between 70,000 and 100,000 technologists in the United States. The supply is much less. In view of this shortage, the country can ill afford the disqualification of any competent technologist.

AMT is just as devoted to assuring quality laboratory work as is the Secretary of Health, Education and Welfare. Disqualification of competent technologists in a time of acute shortage by arbitrary regulations certainly will not upgrade laboratory testing. No such regulations are imposed on hospital laboratories. The Secretary requested from Congress only the authority to set the "same standards" for independent laboratories as for hospital laboratories. We believe he should now be told to stay within that limit.

On behalf of AMT and its 10,000 registrants, let me again thank you for the opportunity to present these views. May I also assure you that AMT stands ready to give its fullest cooperation in correcting this inequitable situation.

APPENDIX 1

MEDICAL TECHNOLOGY PROGRAM

American Medical Technologists is one of the world's oldest and largest registries and associations of medical laboratory technologists. American Medical Technologists' primary purpose is the issuing of credentials of competence to laboratory personnel meeting the Registry's high standards. The most important certification is that of Medical Technologist (M.T.).

A medical technologist is a person who, having completed certain formal training and internship or residency, has passed a qualifying examination and is certified as competent to perform the tests and do the work usually performed in clinical laboratories.

All medical technologists registered by American Medical Technologists are full members of the AMT and enjoy full voting rights in their local AMT state societies and may attend all state, district, and national meetings of the Registry. In this manner each medical technologist has a voice in an important professional association and may benefit from the many scientific, educational, and social functions of this outstanding organization.

REQUIREMENTS

1. Applicant shall be a citizen or resident of the United States, Canada, or other Western Hemisphere nation or dependency, and shall be of good moral character.

2. Applicant shall be a graduate of an accredited high school or equivalent.

3. (a) Applicant shall be a graduate of a medical technology school accredited by the Accrediting Bureau of Medical Technology Schools (18 month course followed by 6 months of residency or internship, or 12 month course followed by 12 months of residency or internship). The residency or internship need not be completed when application is made, or

(b) Applicant shall, if he started training in a school of medical technology on the AMT approved list on June 30, 1964, be a graduate of such an approved school. (This alternative is only for applicants who graduate prior to July 1, 1965), or

(c) Applicant shall, if he started training prior to July 1, 1964, have had not less than three (3) years of approved on-the-job training in a clinical laboratory under proper, qualified supervision (this alternative is only for applicants who began such training prior to July 1, 1964, and will terminate completely on December 31, 1967), or

(d) Applicant shall have successfully completed a course at least twelve months long in a U. S. Armed Forces school of medical technology, and shall have, following such course, worked in a clinical laboratory under qualified supervision long enough to complete a combined school and experience program of at least two year. The school courses and the laboratory experience must be the substantial equivalent of the curriculum and internship or residency required under (a) above. The laboratory experience need not be completed when application is made, or

(e) Applicant shall have had two (2) years, (60 credit hours) of college or junior college including the following minimum course requirements: a minimum of 25 credit hours in the sciences, including 12 in chemistry, bacteriology or parasitology (in any combination); five (5) hours in mathematics; eight (8) hours in biology, genetics, embryology, zoology or anatomy (in any combination) plus one (1) year of residency or internship. (The residency or internship need not be completed when application is made).

4. All applicants must take and pass the Registry examination with a grade of not less than 70%. There are no exceptions.

APPENDIX 2

MINIMUM COURSE REQUIREMENTS OF AMERICAN MEDICAL TECHNOLOGIST ACCREDITED SCHOOLS

Formal training in an AMT accredited school may be completed in either a 12 month school plus a 12 month internship program, or in an 18 month school plus a 6 month internship program.

Requirements for 12-month school program

	Lecture hours	Lab hours
Anatomy and physiology.....	20	10
Medical orientation.....	10	10
General chemistry.....	30	60
Hematology.....	60	140
Bacteriology.....	60	120
Parasitology.....	40	80
Urinalysis.....	25	55
Gastric analysis.....	5	5
Clinical chemistry.....	80	160
Serology.....	30	70
Histological techniques.....	30	60
Basal metabolism and electrocardiograph.....	10	20
Blood banking.....	20	40
Medical ethics.....	15	0
Advanced laboratory procedures, seminars, etc.....	20	80
Total.....	455	910

NOTE.—The student must also successfully complete such additional elective courses as shall cause the total clock hours to be not less than 1,500.

REQUIREMENTS FOR 18-MONTH SCHOOL PROGRAM

The students must successfully complete all the courses required for the 12 month program. Additional hours in these required courses and courses selected from the following list must also be taken to complete 2100 clock hours of instruction :

	Lecture hours	Lab hours
Biology -----	30	60
Zoology -----	30	60
Chemical arithmetic -----	60	0
Elementary physics -----	20	32
Mycology -----	15	45
Virology -----	15	45
Business English -----	55	0
Total -----	680	1,152

RECAPITULATION

Total clock hours required for 12 month school : 1,500.

Total clock hours required for 18 month school : 2,100.

APPENDIX 3

*Program of instruction for medical laboratory procedures (advanced) course,
Letterman General Hospital, San Francisco, Calif.*

Course :	Clock hours
Physiology -----	25
Orientation to courses in pathology and laboratory science -----	4
Parasitology -----	120
Histopathology -----	120
Laboratory administration -----	12
Cytology -----	60
Hematology -----	220
Mathematics -----	20
Bacteriology -----	261
Immunology -----	96
Mycology -----	78
Virology -----	77
Clinical chemistry -----	368
Analytical toxicology -----	39
Advanced urinalysis -----	68
Immunochemistry and blood banking -----	160
Special laboratory subjects (including observation of a post-mortem ; demonstration of specialized techniques and methods ; familiariza- tion with field instruments and techniques in a mobile labora- tory) -----	170
Laboratory supply and maintenance -----	10
Total clock hours -----	1,908

The CHAIRMAN. Mr. Haskins, we appreciate your coming to the committee accompanied by the gentlemen with you at the table. Let me clearly understand. It does not, in your opinion, require a change in the law for these technologists to be considered as technologists. It requires a change within the regulations defining standards for classification of technologists and technicians, as I understand it.

Mr. HASKINS. That is right.

The CHAIRMAN. You and your group did, of course, interest yourselves in the matter at the time the regulations were being developed. Is that true?

Mr. HASKINS. We have had several meetings with representatives of Health, Education, and Welfare, but they don't choose to recognize either our members, the training programs, nor do they seem to wish to cooperate in making reasonable——

The CHAIRMAN. It could be done, however, by a change in regulations.

Mr. HASKINS. Yes, sir.

The CHAIRMAN. If it is not done by a change in regulations, then you are suggesting that the committee require the inclusion of your group within the classification of the regulations as technologists by law?

Mr. HASKINS. Yes, sir.

The CHAIRMAN. Fine.

Any further questions of these gentlemen? If not, we thank you very much for coming to the committee.

Mr. HASKINS. Thank you.

The CHAIRMAN. Governor Erbe. We are pleased this morning to have the Honorable Norman A. Erbe, who is executive director of the American Chiropractic Association, former Governor and former attorney general of the great State of Iowa.

If you will identify those with you at the table, Governor, we would be glad to recognize you, sir.

STATEMENT OF HON. NORMAN A. ERBE, EXECUTIVE DIRECTOR, AMERICAN CHIROPRACTIC ASSOCIATION; ACCOMPANIED BY DR. GEORGE F. POE, PRESIDENT, DR. LEONARD FAY, DEAN, NATIONAL COLLEGE OF CHIROPRACTIC, AND HARRY N. ROSENFELD, WASHINGTON COUNSEL

Mr. ERBE. Thank you, sir. The gentlemen with me, Mr. Chairman, are Dr. George F. Poe of Califon, N.J., president of the American Chiropractic Association, on my left; Dr. Leonard Fay, dean of the National College of Chiropractic at Lumbard, Ill., on my right; and to the far left Harry N. Rosenfield, Esq., ACA's Washington counsel.

The CHAIRMAN. We are pleased to have you gentlemen with us this morning. You are recognized, sir.

Mr. ERBE. Thank you. My name is Norman A. Erbe, and I have served as attorney general and Governor of Iowa. I testify to urge the inclusion of chiropractic care and services within medicare.

I appear here today as executive director of the American Chiropractic Association of Des Moines, Iowa, a national professional body with a membership of 6,246 chiropractors who are licensed by their respective States to provide health service.

In addition, I am specifically authorized to represent the State chiropractic associations of California, Florida, Idaho, Illinois, Michigan, Minnesota, Virginia, and Texas, among others.

PURPOSE OF MEDICARE

Medicare's purpose as expressed by Congress was to provide America's elderly citizens with a national pledge that their bills for medical and health services will be paid. Medicare is, therefore, an insurance

protection to our senior citizens against the financial uncertainties and hardships of ill health.

But the Congress also made it crystal clear what medicare is not:

It is not a Federal program to supplant State regulations of medical and health services;

It is not a Federal control or supervision of the untrammelled right of sick people to obtain health and medical services authorized and licensed by the States.

In fact, Congress was so adamant about what medicare was not that it wrote two basic principles into the very first two sections of the medicare title of the Social Security Act, as follows:

(1) "Prohibition against any Federal interference," section 1801.

(2) "Free choice by patient guaranteed," section 1802.

I regret to say that in its present form the medicare law violates both of these principles in at least one important respect, its failure to provide coverage for the health services provided by chiropractors.

CHIROPRACTIC, A RECOGNIZED HEALTH PROFESSION

First, a few words about chiropractic: Chiropractic is a recognized and licensed health service in 48 States, the District of Columbia, and in Puerto Rico. Each of these States or jurisdictions have specific laws defining the practice of chiropractic, prescribing requirements for licensure, and authorizing chiropractic services and care.

Chiropractors have been classified by the U.S. Public Health Service in a 1966 study as among "medical specialists and practitioners" including pediatricians, obstetricians, and ophthalmologists, among others.

Claims for chiropractic care are paid by more than 600 insurance companies and by workmen's compensation boards of 41 States and the District of Columbia. All Federal agencies accept sick leave certificates signed by chiropractors, and chiropractic care is, of course, a recognized medical expense under Internal Revenue regulations.

NATURE OF CHIROPRACTIC

Chiropractic is a science which utilizes the inherent recuperative powers of the body and the relationship between the musculo-skeletal structures and functions of the body, particularly of the spinal column and the nervous system, in the restoration and maintenance of health. Chiropractic practice is the specific adjustment and manipulation of the articulations and adjacent tissues of the body, particularly of the spinal column, for the correction of nerve interference and includes the use of recognized diagnostic methods as indicated.

Patient care is conducted with due regard for environmental, nutritional, and psychotherapeutic factors, as well as first aid, hygiene, sanitation, rehabilitation, and related procedures designed to restore or maintain normal nerve functions.

Chiropractic is based on the premise that the relationship between structure and function in the human body is a significant health factor and that such relationships between the spinal column and the nervous system are the most significant, since the normal transmission and expression of nerve energy is essential to the restoration and maintenance of health.

Chiropractic is the largest drugless healing profession. It does not include the practice of surgery.

Appendix I attached to my statement sets forth a short description of the extensive professional and scientific education in helath sciences required before licensure as a chiropractic doctor.

Chiropractic professional colleges require a minimum of 4 academic years of professional resident study. Eight chiropractic colleges are affiliated with the American Chiropractic Association which spends a very considerable portion of its income for improvement of the Nation's chiropractic educational program.

FREEDOM OF CHOICE AND STATES RIGHTS

I respectfully submit that the present medicare law violates the basic principles of 1801 and 1802 by its failure to provide coverage for chiropractic health services. Let me be specific.

FIRST, STATES RIGHTS ARE ABRIDGED BY FEDERAL LAW

The assurance seemingly provided by section 1801's "prohibition against any Federal interference" is vitiated through interference with the States' freedom effectively to make available to their elderly citizens the health services of chiropractors.

This is a serious matter since, as I have already noted, 48 States, Puerto Rico, and the District of Columbia, all have licensing laws which recognize the practice of chiropractic and authorize its health services for their citizens.

Therefore, the Federal medicare law, by denying coverage of chiropractors, penalizes the citizens of these States and interferes with the operation of such State laws within the respective State boundaries.

As a former Governor of the State of Iowa, I feel especially sensitive about abridgement of States rights by the Federal Government. And this denial of effective States rights in title XVIII (medicare) is all the more strange because true States rights, and the coverage of chiropractic services, are in title XIX (medicaid).

Our latest survey shows that of the 26 States which have already adopted medicaid legislation, 12 already include chiropractic services. These 12 States are California, Idaho, Iowa, Michigan, Minnesota, Nebraska, New Mexico, New York, North Dakota, Ohio, South Dakota, and West Virginia.

Thus we have the following odd results under the present Social Security Act:

1. The medically indigent can obtain chiropractors' services under medicaid (title XIX).

2. But the medically self-sufficient cannot obtain chiropractors' services under medicare (title XVIII). This is an unjust and unfair discrimination against the self-sufficient senior citizens of our Nation who should also be entitled to exercise their right of selection of health care.

We respectfully urge that medicare eligibles are entitled to chiropractic services under title XVIII, if such services are authorized by the State in which the medicare patient chooses them.

SECOND, FREEDOM OF CHOICE IS DENIED TO PATIENTS

America's self-supporting elderly are denied effective freedom of choice to obtain the needed and beneficial health services of State-licensed chiropractors. And this prevails despite 1802.

If there was one continuing thread during the entire congressional debate on medicare, as well as in the prior 20 years of discussion, it was freedom of choice by the patient to obtain health services from any qualified institution, agency, or person.

This was the guarantee intended by section 1802, a freedom of choice to "obtain health services." This is what the voluntary insurance premium in title XVIII was intended to buy. For example, this freedom of patient choice was allowed as to optometrists in the medical assistance title:

* * * if eyeglasses are provided, the individual must be free to choose whether these are prescribed by a physician skilled in the diseases of the eye or an optometrist * * *

(Conference report, H. Rept. No. 682, 89th Cong., 1st sess., p. 69). This same freedom of choice in medicine was allowed for Christian Science nursing homes, "if the individual elected to have them so covered" (conference report, *supra*, p. 43).

When Congress talked and legislated "freedom of choice," it obviously had in mind the basic purpose of medicare, enabling older people to afford to pay for needed health cost protection.

Therefore, when "freedom of choice" is denied, medicare in effect denies older people the health protection they want and need, as well as the independence and dignity which medicare is designed to assure. We are talking here not only of fundamental theories of the relation between the Federal and State Governments and the relation of the American citizen to his government, but also of the individual health, comfort, and well-being of each and every senior American.

Let me hasten to say that as a former Governor, I am fully aware of the need for compromises that often have to be made before major laws are enacted. This of course was equally true in 1965 with the medicare bill.

But I respectfully submit that the time has now come for changes in medicare that will enable State laws on permissible health services to be effectively operative within the borders of the State.

If, as the medicare law states, there is to be a meaningful "prohibition against any Federal interference" then the medicare law should be amended to allow coverage of chiropractic health services authorized and licensed under State law. Freedom of choice of health care is the basic right of all Americans.

I believe it fair and just to say that the coverage of chiropractors' services under medicare is a test of the genuineness of our dedication to the principles proclaimed in sections 1801 and 1802 of the medicare law:

"Prohibition against any Federal interference."

"Free choice by patient guaranteed."

COMPREHENSIVE HEALTH CARE

Just last week the President directed the Department of Health, Education, and Welfare to take steps to "lower the cost of medical

services without impairing the quality." He did so after receiving a report from HEW that the cost of doctors' fees rose 7.8 percent in 1966—the biggest annual increase since 1927—and the daily hospital charges rose 16.5 percent in 1966 (the largest annual increase in 18 years).

HEW made recommendations of means to decrease health care costs. One such recommendation was that "private and public health insurance plans should be broadened to include more alternative types of medical care."

We thoroughly agree with this, and suggest that comprehensive health insurance coverage under medicare cannot be achieved without chiropractors' services as well as podiatrists' services as proposed in H.R. 5710.

And now we have HEW's assurance that such "alternative types of medical care" may actually reduce costs as well as provide comprehensive health service.

Studies, such as the impartial study by the Florida industrial commission, amply sustain HEW's cost-reduction recommendations.

PROPOSED AMENDMENT

The fundamental need is to provide for the opportunity of the patient to select chiropractic care and services under title XVIII. The particular statutory manner in which this is accomplished is of lesser importance, provided, of course, it be effective to achieve its full purpose.

Three different means at least seem to have been suggested: First, the proposals in bills such as H.R. 2107 (Helstoski), H.R. 3789 (Murphy of New York) or H.R. 5608 (Fino) to amend section 1861(r) so as to include chiropractors with respect to services which they are legally authorized by the State to perform as chiropractors.

Second, the provision already in the medicaid program, section 1905(a)(6), providing for coverage of "a medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law."

Third, the method followed by H.R. 5710 is amending section 1861(s). I attach to my statement, as appendix II, an amendment to H.R. 5710 to accomplish this purpose for chiropractors services.

This committee has before it a tremendously significant task. We respectfully suggest that America's senior citizens will be everlastingly grateful to this committee and the Congress if accorded the right to choose chiropractic care and services as part of the health services provided under the medicare program (title XVIII) just as it is already authorized under medicaid (title XIX).

Anything less would be an unwarranted discrimination against medicare eligibles, a repudiation of the national pledge to provide (through medicare) for payment of medical and health services, an abridgment of States rights, and a denial of freedom of choice by American citizens.

(Apps. I and II referred to follow:)

APPENDIX I

EDUCATION REQUIREMENTS FOR LICENSURE AS DOCTOR OF CHIROPRACTIC

1. CHIROPRACTIC EDUCATIONAL REQUIREMENTS

The chiropractic doctor is educated in chiropractic principles and practice, anatomy, biochemistry, microbiology, pathology, physiology, public health, diagnosis and x-ray, clinical disciplines, and related health sciences. Beginning with these basic subjects, the chiropractic student spends a major part of the first two years (of a four-year course—not less than 4200 clock hours) in mastering these fundamentals. The remaining two years are devoted to practical or clinical studies dealing with the diagnosis and treatment of disease, and working with patients in applying chiropractic principles and gaining experience of practice. Approximately one-half of the time of the last two years is spent in the clinics of the college of his choice.

2. PRE-PROFESSIONAL EDUCATION

In twenty-six states, the minimum educational requirements include at least two years of pre-chiropractic college work. Within a short time, this pre-professional preparation is expected to extend throughout the United States and Canada. Over fifty percent of all students enrolled in approved chiropractic colleges have from one to four years of preliminary college training.

3. STATE EXAMINING BOARDS

Each state has a State Examining Board composed of doctors of chiropractic. In a few states, there are composite boards of doctors of chiropractic and doctors of medicine.

APPENDIX II

PROPOSED AMENDMENT TO H.R. 5710 TO INCLUDE CHIROPRACTIC SERVICES IN MEDICARE

1. SECTION 127, PAGE 55, LINE 23

After the word "or," insert the following: ", chiropractors' services"

Note: line 23 would then read as follows: "services" the following: ", chiropractors' services or podiatrists' services"

2. Page 56, between lines 7 and 8, insert the following new subsection: "Chiropractors' Services

"(aa) The term 'chiropractors' services' means services performed by a chiropractor, but only with respect to functions which he is legally authorized to perform as a chiropractor by the State in which he performs them."

Mr. WATTS (presiding). We thank you, sir, for your fine statement. Is there anybody else with you that has any statement?

Mr. ERBE. No, sir.

Mr. WATTS. Any questions?

We certainly thank you. Your statement will be given every consideration by the committee.

Mr. ERBE. Thank you, sir. I would like to express our appreciation for the invitation to appear. Thank you, sir.

(The following supplements to Mr. Erbe's statement were received by the committee:)

SUPPLEMENT A

FLORIDA INDUSTRIAL COMMISSION DATA ON COMPARATIVE COSTS OF SERVICES BY CHIROPRACTORS AND MEDICAL DOCTORS

1. In 1960 a study was made of the workmen's compensation records of the Floriday Industrial Commission. The report was entitled "A Survey and Analysis of the Treatment of Sprain and Strain Injuries and Industrial Cases.

2. The purpose of the research was to compare the (1) average treatment costs, (2) worktime losses, and (3) services rendered per case for back injuries, as treated by chiropractors and medical doctors.

3. The study covered 19,666 individual cases, and was checked at each stage by the First Research Corporation, a nationally recognized and independent research organization.

4. The findings are that as to sprains and strains of the neck, spinal column-vertebrae and back:

	Handled by—	
	Chiropractor	Medical doctor
(A) The cost of the average case was as follows:		
Total treatment costs.....	\$51	\$65
Compensation costs.....	9	37
Total.....	60	102
(B) The average worktime lost (days).....	3	9

5. Thus, when a sprain and strain case was handled by a medical doctor rather than a chiropractor—

(A) *Treatment costs* averaged 27.5% more.

(B) *Compensation costs* averaged 311% more.

(C) *Worktime losses* averaged 300% more.

6. Benefits from chiropractic care in such cases—

(A) Reduced medical costs.

(B) Reduced compensation costs.

(C) Reduced loss of salary and pain to employee.

(D) Reduced loss of manpower to employer.

SUPPLEMENT B

Summary of average cost per case under chiropractic care and all professions

Source of information	Cost under chiropractic care	Medical cost, all professions
California:		
Old-age security.....	\$33.31	\$76.67
Aid to the blind.....	39.14	81.32
Aid to needy disabled.....	45.12	121.68
Auto injuries.....	131.29	166.97
Florida: Back injuries.....	51.00	61.77
Colorado: Back injuries.....	20.82	31.67

Source: H. G. Higley, "Cost of Chiropractic Services" (unpublished, September 1966), p. 8.

Mr. WATTS. The next witness is Mr. George L. Quisno and Mr. Everett A. Wogan. Come around, gentlemen. One of our colleagues, the Honorable Clarence E. Miller, of Ohio, was very desirous of being here this morning and asked me to convey his regrets to you that he was unable to be here today and introduce you fine gentlemen. I know he planned to be here, but he had to go back to his district. He nevertheless wanted you to know that he appreciates your taking the time to come here and present your views to the committee. He knows that your statement will be very helpful to the committee's consideration of the medicare program.

So you are both recognized and you may proceed as you desire.

STATEMENT OF GEORGE L. QUISNO, HILLTOP LABORATORIES, CINCINNATI, OHIO, AND EVERETT A. WOGAN, WOGAN LABORATORIES, LANCASTER, OHIO

Mr. QUISNO. Thank you, sir.

Mr. WOGAN. Thank you. Mr. Chairman, we will try to make this real short.

Mr. WATTS. All right. You use your own judgment about it, sir.

Mr. WOGAN. When we get through we would hope that there might be some questions from some of the committee members.

Mr. WATTS. All right, sir.

Mr. WOGAN. I am here as an individual operating a laboratory to speak on the House bills H.R. 6675 and H.R. 5710 as proposed as it has to do with laboratory directors. My name is Everett A. Wogan. I will read this because it was prepared for me.

Mr. WATTS. Yes, sir.

Mr. WOGAN. I am appearing before your committee as the owner and operator of a clinical laboratory for the past 21 years, located presently at 401 East Main Street, Lancaster, Ohio. My education and training in the clinical laboratory field dated from 1941 when I attended and graduated from the Medical Field Service School, Fort Sam Houston, San Antonio, Tex.

I might deviate just a minute here. I still have the manual that my good friend back here, Mr. Haskins, was talking about in the laboratory today.

Upon satisfactorily completing the Army's training program, I became director of the clinical laboratory at Foster Field, Victoria, Tex., where I remained until discharged from the service 4 years later. I then returned to my hometown of Lancaster, Ohio, sought and obtained the necessary financial backing to open by own clinical laboratory where I am still engaged in business.

This laboratory, under my continuous direction and supervision, has passed every State and National proficiency testing program to which it has been subjected, and has earned the faith and confidence of public health officials and physicians within a radius of 40 miles of my place of business.

My clientele includes approximately 80 practicing physicians, the Lancaster Department of Health, the Fairfield County Health Service and the Veterans' Administration. I have attempted to follow scrupulously all health and safety requirements and the ethics of my profession. My community and the surrounding area from which my business has grown has an acute need for the testing services which are being performed at the Wogan Laboratory.

Nevertheless, because I am not a college graduate, under the regulations recently adopted by the Secretary of Health, Education, and Welfare, my laboratory cannot be accredited to perform the clinical tests which are part of the medicare program.

I want to deviate right here—unless I pass a written examination. I am not alone in this dilemma. Many reputable, first-rate clinical laboratories across this land are owned and operated by directors who do not possess the educational requirements which have been imposed by the Secretary of Health, Education, and Welfare pursuant to au-

thority delegated to him by the Congress last year. There has not been called to my attention any other instance when an appropriate "grandfather" clause has not accompanied governmental regulations in a new field.

All that I ask for myself and for the others in a similar situation—and there are many—is that we be permitted to continue to render clinical laboratory testing for the medical profession and for health authorities in those areas where we have proven by experience that we are qualified to render such services.

In that regard, I endorse the proposal which I understand will be made by Bernard I. Diamond in his official presentation on behalf of the American Association of Bioanalysts.

And, Mr. Chairman, on behalf of myself and Mr. Quisno we want to thank you and your committee for the privilege to appear before your committee today.

Mr. WATTS. Does the other gentleman have a statement?

Mr. WOGAN. No, sir.

Mr. WATTS. We certainly thank you for calling this to our attention. Are there any questions?

It seems to me I have a little familiarity with this. Do they require that you have a doctor connected with the laboratory? Is that what the educational requirement is?

Mr. WOGAN. The minimum is a bachelor's degree I believe.

Mr. WATTS. Bachelor's degree in what?

Mr. WOGAN. The minimum is a bachelor degree with 6 years experience right now. This is a minimum going in, to qualify without taking the written examination.

Mr. WATTS. That doesn't require a medical education? Does it require that just the head of the laboratory have that, or just one person in your laboratory, or what?

Mr. QUISNO. The director must have these qualifications.

Mr. WATTS. And your idea is that, since you have been performing these services and other laboratories have been performing them satisfactorily over the years, a change in the rules of the game is not exactly fair?

Mr. QUISNO. That is right.

Mr. WOGAN. It is immaterial to us whether the regulations are changed that are written up or the law is changed itself as long as the regulations can't be reversed next year.

Mr. WATTS. Does this bachelor's degree have to be in the field of laboratory work?

Mr. WOGAN. Yes, sir.

Mr. QUISNO. Chemistry, physics, the biological sciences.

Mr. WATTS. We certainly thank you for appearing and I assure you we will discuss this at the appropriate time.

Any questions of these gentlemen?

Mr. BURKE. I would like to ask how many of these clinical laboratories are there around the country?

Mr. WOGAN. It is so hard to tell because a lot of States don't have even a registration program.

Mr. BURKE. There is no organization representing this group?

Mr. WOGAN. Yes, sir. Mr. Diamond, I think, can fill you in, who will be following me I think next here. I think he can fill you in

on the number of laboratories, but really in the State of Ohio at the present time we have no regulations, no licensure that would require the registration of the laboratory so they don't know where they are at, where they are located, what kind of work they are doing, unless they participate under a voluntary evaluation program, which we do, to be sure we are doing the work correctly.

Mr. BURKE. In other words, there is no set standard set up. Do you know of any States that have any regulations?

Mr. WOGAN. Oh, yes, sir; 13 States, I think, have regulations now. We have a bill just about ready to go in the legislature in Ohio at the present time. I would hope when we get back in Columbus tonight that this bill will be ready.

However, this will be the 14th one, that's all.

Mr. BURKE. Thank you.

Mr. WATTS. Thank you, that is all, gentlemen.

Mr. WOGAN. Thank you.

Mr. WATTS. The next witnesses appear on behalf of the International Society of Clinical Laboratory Technologists, Mr. Tom Robinson and Dr. Stanley Reitman.

We are delighted to have you. Do you have one spokesman?

STATEMENT OF TOM ROBINSON, PRESIDENT, INTERNATIONAL SOCIETY OF CLINICAL LABORATORY TECHNOLOGISTS; AND DR. STANLEY REITMAN, MEMBER, BOARD OF DIRECTORS, AND REIN J. VANDER ZEE, WASHINGTON COUNSEL

Mr. ROBINSON. Two.

Mr. WATTS. You may proceed.

Mr. ROBINSON. Mr. Chairman, I would like to introduce Dr. Reitman and Mr. Vander Zee with me.

Mr. WATTS. You are recognized.

Mr. ROBINSON. Mr. Chairman and members of the House Ways and Means Committee, my name is Tom Robinson and in addition to directing a laboratory in my home town of Tulsa, Okla., I am the president of the International Society of Clinical Laboratory Technologists, an organization of clinical laboratory personnel with almost 3,000 members residing in all 50 of the United States.

Our society maintains its administrative offices at 805 Ambassador Building, St. Louis, Mo. Appearing with me this morning is Dr. Stanley Reitman, a practicing physician and a member of the board of directions of our society. Dr. Reitman resides and practices medicine in St. Louis, Mo.

I have been personally active in the clinical laboratory as a technologist and a laboratory director for over 16 years and I was for 6 years chief laboratory technologist at the Oklahoma Osteopathic Hospital, Tulsa, which, incidentally, is the second largest osteopathic institution in the United States.

Since 1957, I have operated the Robinson Laboratories in Tulsa. Dr. Reitman has been most active in the field of laboratory medicine for the past 12 years and has won international recognition as the co-developer of one of the most widely used laboratory techniques, the Reitman-Frankel transaminase procedure. This is for diagnosing cardiac problems.

In addition, Dr. Reitman has been most active in the training of laboratory personnel as a director of one of the oldest schools of medical laboratory technology in the United States, the Gradwohl School in St. Louis.

We wish to testify on H.R. 5710, the Social Security Amendments of 1967, insofar as we believe these amendments should be modified to correct discriminatory and inadequate regulations propounded by the Social Security Administration to implement the Medicare Act. We shall concentrate on those provisions which apply to the qualifications of laboratory technologists and technicians.

First, social security regulations divide clinical laboratories into three categories:

1. Laboratories in private physicians, offices—for which there are no regulations for laboratory personnel.
2. Hospital laboratories—for which there are meaningless regulations.
3. Independent laboratories—for which discriminatory and inadequate regulations are established.

As a laboratory director in both hospital laboratories and independent laboratories, I personally cannot see why there should be a different set of regulations for these laboratories. With the chairman's permission, I would like to ask Dr. Reitman to continue our presentation.

Mr. WATTS. Dr. Reitman.

Dr. REITMAN. Mr. Chairman and members of the committee, as Mr. Robinson has indicated, the Social Security Administration has divided laboratories into three categories. As a practicing physician, I insist that laboratory tests performed should be in the same order of excellence regardless of the laboratory's location and ownership. To effectively regulate one category of laboratories is grossly discriminatory and inadequate. We think this must be corrected.

Another area of great concern is the shortage of laboratory personnel. There is unequivocal agreement that a critical shortage of such personnel does exist. However, despite this, the social security regulations would exclude a significant number of clinical laboratory personnel from employment in the independent laboratory, although these very same individuals are permitted to work for some 5 years under the medicare program.

The regulations as published would, after June 30, 1967, allow only technologists and technicians trained under the American Society of Clinical Pathologists approved programs to work in independent laboratories.

As an afterthought, in their second set of regulations, the Social Security Administration also included personnel training in Armed Forces schools. In the Regulations for Independent Laboratories, under 405.1315(b), subparagraph 5 and 405.1315(d), subparagraph 4, Standards for Technologists and Technicians, individuals qualified by reason of experience as of July 1, 1966, may work for 5 years and then as of July 1, 1971, they will no longer be acceptable for employment in the independent laboratory regardless of their competence.

In addition, graduates of private schools are excluded from employment in an independent laboratory despite the fact that thousands of

these individuals are presently working as technologists, and attesting to their competence are innumerable letters from laboratory directors, including many pathologists.

To exclude these people will only aggravate an already acute shortage, without improving patient care. In my opinion, the 1-year American Society of Clinical Pathologists assistance program of on-the-job training is far inferior to formal education programs such as those offered by many private schools of medical technology.

It is almost inconceivable that the Social Security Administration should designate these individuals as laboratory technicians, when the pathologists who developed and controlled this program consider the trainees to be only laboratory assistants.

One further comment: We think this committee should be aware of the fact that according to the Code of Ethics of the Registry of the American Society of Clinical Pathologists, their registrants are permitted to work only for a laboratory directed by a licensed physician.

Therefore, only pathologists and other licensed physicians could own and operate independent laboratories. This would tend to perpetuate the monopoly which the U.S. Department of Justice charges already exists in the clinical laboratory field.

One of the concepts of the entire set of regulations that alarms many is that a Federal agency attempts to preempt what has historically been the right of each individual State, and that is the right to license the individual practitioners of a profession by State statute.

Under the regulations, the Social Security Administration superimposes Federal requirements for personnel where there are already licensing statutes in existence. Statutes regulating the clinical laboratory already exist in Alabama, California, Connecticut, Florida, Hawaii, Illinois, Maryland, New Hampshire, New Jersey, New York, Pennsylvania, and Rhode Island. Many other States are now considering such legislation and Mr. Robinson can testify on the situation in Oklahoma, if the committee should desire.

We feel the Federal Government should allow the States to effectively regulate the clinical laboratory personnel. We have, through our attorneys, filed our objections to these regulations with the Honorable Robert M. Ball, Commissioner of the Social Security Administration, the last instance by letter on January 14, 1967. To date we have not received any indication from the Social Security Administration that our objections were being given any consideration.

We, therefore, respectfully request that this committee recommend to the Congress that by legislative action they establish the following conditions for participation of clinical laboratories in the health insurance for the aged program:

1. That one set of regulations be established for all clinical laboratories which participate in the program.
2. That State licensing statutes for laboratories and personnel where they exist shall be deemed sufficient for participation in the program. Provisions should also be made for States which enact such legislation in the future.
3. For technologists: Formal education requirements should be a baccalaureate degree in a science closely allied to the medical labora-

tory field and in addition 1 year of experience in a clinical laboratory subsequent to graduation.

4. Individuals who by June 30, 1971, have achieved at least 10 years of experience as a clinical laboratory technologist should be considered acceptable as such.

5. For technicians: Individuals who have successfully completed a formal course of instruction equivalent to 60 semester hours in medical laboratory technology in a junior college, private school, or Armed Forces school should be allowed to enter a laboratory as a technician intern. After 1 year or such internship, the individual shall be considered qualified as a clinical laboratory technician.

6. Individuals who by June 30, 1971, have achieved at least 5 years of work experience as a clinical laboratory technician should be deemed qualified as such.

I would like to take this opportunity to thank the chairman and the committee for the privilege of being heard.

Mr. WATTS. Thank you very much for calling our attention to this. Any questions?

Mr. BURKE. I would like to ask a question.

Mr. WATTS. Mr. Burke.

Mr. BURKE. Why is it that the clinical laboratories haven't petitioned the various legislatures down through the years to set up minimum standards?

Dr. REITMAN. As I understand the question, why haven't the clinical laboratories through the years—

Mr. BURKE. Why haven't they voluntarily on their own part for the protection of the public seen to it that a set of minimum standards were set up?

Dr. REITMAN. This is a question I honestly can't answer, since I am representing a society of technologists rather than the laboratories. I don't know why the laboratories themselves haven't requested State licensure or requested State legislatures to do something of this sort.

Our society is a relatively new one, is approximately 5 years old, and from its inception it has been one of our primary goals to seek State licensure of medical laboratory personnel and we have gone before the legislatures.

In fact, as I indicated, Mr. Robinson is actively participating with a group now seeing State licensure for their personnel in Oklahoma. A member of our organization, a Mr. William Jaegers, in Missouri, so I can only speak for the organization which I represent and we have since its inception sought such State licensure.

Mr. BURKE. I notice that Massachusetts is not included as one of the States regulating clinical laboratories and I am surprised because the State has such a medical background.

Do you know whether there is any legislation pending in Massachusetts on this matter?

Dr. REITMAN. Mr. Robinson informs me that there is. This is because I think one of the activities of our society has been to try to get legislation in actually the 50 States of the United States so that there is some activity in almost every State at the present time and a good deal of this has been brought about because we feel that this is the best way and really the only way that the public interest can be thoroughly protected.

Mr. BURKE. Thank you. That is all, Mr. Chairman.

Mr. WATTS. Are there any other questions?

Thank you, gentlemen.

Mr. ROBINSON. Thank you.

Mr. WATTS. The next witness will be Dr. Conley, former executive director of the National Association for Practical Nurse Education and Service.

Come around, please. We are delighted to have you before the committee. Give your full name and title to the reporter, please. Then you may proceed.

STATEMENT OF DR. VERONICA CONLEY, FORMER EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION AND SERVICE, ACCOMPANIED BY JOHN K. PICKENS, GENERAL COUNSEL

Dr. CONLEY. Mr. Chairman and members of the committee, my name is Dr. Veronica L. Conley of 92004 Barden Road, Bethesda, Md. I am accompanied by John K. Pickens, general counsel for the National Association for Practical Nurse Education and Service.

I am the executive editor of the Journal of Practical Nursing and former executive director of the National Association for Practical Nurse Education and Service, Inc. (1962-65). Previous to this position, I was employed for 15 years by the American Medical Association in its division on therapy and research. During this time, I established the Department of Nursing of the American Medical Association and became its first director.

Prior thereto, I was instructor in nursing at Ohio State University, and during World War II was in the USNR Nurse Corps as an instructor in Hospital Corps School.

I am a registered nurse with a Ph. D. in adult education. I received my bachelor of arts degree from Boston University, followed by a master of nursing degree from Yale University. After 2 years of service in the USNR Nurse Corps during World War II, I matriculated at the University of Chicago and earned my master of arts and doctor of philosophy from that university.

Mr. Chairman, I shall not read my statement but will present a summary.

Mr. WATTS. You may summarize it, but the statement will appear in the record in full.

Dr. CONLEY. Thank you. Condition V—regarding nursing services—of the “Conditions of Participation” under title XVIII promulgated by the Department of Health, Education, and Welfare, requires that a licensed practical nurse who is in charge of a shift, that is, a supervisor of a shift, must be a graduate of a State approved school of licensed practical nursing.

The purpose of my statement is to present reasons why the licensed practical nurse, or LPN as she is called, who received that license by waiver should be considered as qualified under certain circumstances to assume supervisor responsibility.

First, it should be pointed out that practical nurses licensed by waiver were licensed by the respective States only after evaluation

by the appropriate State agency, usually the State board of nursing. License by waiver implied recognition by individual States of the principle of equivalency between training and prolonged experience in learning situations.

Second, licensed practical nurses by waiver have consistently shown an eagerness for continuing education. Many have taken extension and other courses. For example, State practical nursing associations have sponsored over the years courses of 64 hours, 240 hours, and 360 hours specifically for the waived licensed practical nurse. These courses in addition to the years of experience make many LPN's by waiver as qualified, and perhaps even better qualified, geriatric nurses than a recent graduate of a State approved school who has had little or no experience.

This is not a criticism of a teenager who has recently graduated from a State approved school to say that in most instances she neither possesses the patience nor tolerance toward the elderly and often not the skills which more mature women possess. There are also a relatively high number of men among waived licensed practical nurses, many of whom prefer geriatric nursing.

Third, a proportion of practical nurses licensed by waiver have a longer formal education period than the current 1-year practical nurse program. These are the women who originally matriculated in schools of professional nursing and who for reasons of marriage, finances, and perhaps ill health had to drop out. These women were often highly motivated toward caring for the sick and when the opportunity presented itself for licenses as a practical nurse by waiver they obtained such a license.

There is no precise figure on the percentage of such women among waived LPN's, but it may be as high as one-fifth of the total.

Fourth, others among the waived LPN's attended schools of practical nursing before the State had established licensure for practical nurses and before a system of State approval of their educational programs had been established. These schools before State approval programs existed may have had national accreditation. For example, the District of Columbia did not provide licensure of practical nurses until 1960 and therefore had no State approval of schools until that date. Although two schools at least in the District were nationally accredited the graduates of these schools prior to 1960 are licensed by waiver.

I should add here for clarification that 48 States use the term "licensed practical nurse," while California and Texas use the term "licensed vocational nurse."

However, in this statement when I use LPN for licensed practical nurse I mean licensed vocational nurse as well.

It seems unfair that a qualified waived licensed practical nurse should be precluded from acting as a shift supervisor. If an LPN has served as a shift supervisor and has passed a standard State examination, she should be recognized on the basis of her ability. It has been suggested, by many, that waived nurses should be classified on the basis of their waivers.

Those who are qualified should be allowed to serve as shift supervisors. The regulations of the Department of Health, Education, and Welfare refuse to recognize this. Since almost 50 percent of all

licensed practical nurses are waived, this regulation unnecessarily aggravates the shortage of licensed practical nurses. Colorado is an example. In 1965 Colorado had 2,724 LPN's licensed by examination and 2,600 licensed by waiver. The failure to fully recognize the capabilities of the waived licensed practical nurse handicaps nursing homes more than hospitals as frequently licensed practical nurses on the second and third shifts are the only nurses on these shifts or these periods of duty.

Accordingly, the nursing home would be forced to discharge the waived LPN and attempt to find such nurses who are graduates of a State approved school. This would not be true of hospitals.

As a temporary expedient HEW issued a telegraphic change dated December 12, 1966, a copy of which is attached to my statement. While this offers a welcome temporary relief, it does not change the basic need. It allows the waived nurse to serve as a shift supervisor, but it is a temporary action. The conditions do not classify waived licensed practical nurses to serve on the basis there of training, ability, experience, or knowledge.

We suggest an amendment which would require the Secretary to take these other valid factors into consideration in determining the qualifications of licensed practical nurses.

To recapitulate, (1) the waived licensed practical nurse is almost always a mature highly motivated person who is often as qualified and sometimes better qualified by experience to take care of geriatric patients; (2) the waivers of an educational requirement for licensure were originally given by individual States on the basis of generally accepted criteria; (3) a great proportion of the LPN's are licensed by waiver today.

In many States as high as 50 percent are so licensed. To preclude these men and women from providing supervisory services on a shift in a nursing home greatly complicates the already critical manpower problem in such facilities.

In conclusion, we proposed that section 1861(j) of the Social Security Act, as amended, be amended by adding at the end of said subsection the following new paragraph:

In determining the qualifications of a licensed practical or licensed vocational nurse to serve as a shift supervisor in tended care facilities, or any similar duty under Title XVIII or Title XIX hereof, the Secretary shall take into consideration the total education and training (including refresher and extension courses), successful completion of a standard state board examination, experience, ability and dedication to nursing as well as graduation from a state approved school or a school accredited by a recognized national accrediting body.

(The statement referred to follows:)

STATEMENT OF DR. VERONICA L. CONLEY, FORMER EXECUTIVE DIRECTOR AND PRESENT EXECUTIVE EDITOR, NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION AND SERVICE (NAPNES)

Mr. Chairman and Members of the Committee:

I am Veronica L. Conley, Executive Editor of the Journal of Practical Nursing and former Executive Director of the National Association for Practical Nurse Education and Service, Inc. (1962-65). Previous to this position, I was employed for fifteen years by the American Medical Association in its division on Therapy and Research. During this time, I established the De-

partment of Nursing of the American Medical Association and became its first director. Prior thereto, I was instructor in nursing at Ohio State University, and during World War II was in the USNR (NC) as an instructor in Hospital Corps School.

I am a registered nurse with a Ph.D in Adult Education. I received my bachelor of arts degree from Boston University, followed by a master of nursing degree from Yale University. After two years of service in the USNR (NC) during World War II, I matriculated at the University of Chicago and earned my M.A. and Ph.D from that institution.

PROBLEM OF WAIVERED LICENSED PRACTICAL NURSE

Condition V (regarding nursing services) of the "Conditions of Participation," under Title XVIII, promulgated by the Department of Health, Education and Welfare (HIM 3, 3-66) requires that a licensed practical nurse who is in charge of a shift (a supervisor of a shift) must be a graduate of a state approved school of licensed practical nursing.

Many who are presently waived licensed practical or licensed vocational nurses have commenced registered professional nursing programs of 3, 4 or 5 years in length. In some cases, these individuals have had to stop their R.N. courses after 2, 5, or 8 months or more in training because of marriage, lack of finances or for other reasons. At this point many of them have then obtained a waiver and taken the state examining board examination for licensed practical nurses. These individuals are licensed by waiver because they did not graduate from a state approved school of [licensed] practical nursing. In many instances, these nurses have had a longer period of training than a graduate of a state approved school.

Until the last few years, many states did not have programs with approved schools. During this period, there were several nationally accredited schools. The standards and criteria for accrediting these schools were later used as the basis for state approval. A graduate of a school for licensed practical nurses in 1960 which was not state approved could take the same identical course and program as a graduate in 1961 (the year in which the state approval program commenced.) Both took and passed the state board examination. The 1960 graduate although she took the same course and program is considered to be licensed by waiver, whereas, the 1961 graduate is not. In fact it was not until 1960 that the District of Columbia provided licensure for practical nurses.

I should add here, for clarification, that 48 states use the term "licensed practical nurses;" California and Texas use the term "licensed vocational nurses." They both mean the same.

In many instances, waived licensed practical nurses have continued to take extension and other courses. Many of them because of their experience are as good as, and in many cases, are better geriatric nurses than a recent graduate of a state approved school who has had little or no experience. It is not a criticism of a teenager who has recently graduated from a State approved school to say that, in most instances, she neither possesses the patience nor tolerance toward the elderly and often not the skills which more mature women possess. There are also a relatively high number of men among waived licensed practical nurses, many of whom prefer geriatric nursing.

It should be pointed out here that practical nurses licensed by waiver were licensed by the respective states only after evaluation by the appropriate state agency—usually the State Board of Nursing. License by waiver implied recognition by individual states of the principle of equivalency between training and prolonged experience in learning situations.

It seems unfair that a *qualified* waived licensed practical nurse should be precluded from acting as a shift supervisor. If an LPN has served as a shift supervisor and has passed a standard state examination, she should be recognized on the basis of her ability. It has been suggested, by many, that waived nurses should be classified on the basis of their waivers.

Those who are qualified should be allowed to serve as shift supervisors. The regulations of the Department of Health, Education and Welfare refuse to recognize this. Since almost 50% of all licensed practical nurses are waived, this regulation unnecessarily aggravates the shortage of licensed practical nurses. Colorado is an example of a state which is in better shape than others. All

waivers were discontinued in 1957 to become effective July 1, 1958. The following table shows the situation as of July 1, 1965:

Licensed by examination-----	2, 724
Endorsement (reciprocity)-----	591
Licensed by waiver-----	2, 671
Total-----	5, 987

It handicaps nursing homes more than hospitals as frequently licensed practical nurses on the second or third shifts are the only nurses on these [shifts] periods of duty. Accordingly, the nursing home would be forced to discharge the waived licensed practical nurse and attempt to find such nurses who were graduates of a state approved school. This would not be true in a hospital!

As a temporary expedient, HEW issued a telegraphic change dated December 12, 1966, a copy of which is attached hereto, allowing waived nurses to serve as shift supervisors. The conditions are unrealistic and do not classify waived licensed practical nurses to serve on the basis of their training, ability, experience or knowledge. We suggest an amendment which would require the Secretary to take these other valid factors into consideration in determining the qualifications of licensed practical nurses.

Originally Title XIX regulations were the same as Title XVIII regulations. We now understand that the Under Secretary has proposed new regulations under Title XIX which provide as follows:

"h. The facility provides 24-hour nursing services adequate in quality and amount to meet the needs of the patients who are admitted to, and remain in, the facility. The nursing service is directed by a registered, professional nurse who is employed full time in the facility and is responsible for the total nursing service. *At all times, there is a registered professional nurse, or a licensed practical nurse who is a graduate of a State approved school of practical nursing, in charge of the nursing service except that, in those instances in which a licensed practical nurse who is not a graduate of an approved school was successfully discharging the responsibilities of a charge nurse on July 1, 1967, such nurse may be employed in this capacity, only if she has completed training satisfactory to the appropriate State licensing authority.*"

We have the same objections to this proposal. We do not want a so-called grandfather clause that would cover all licensed practical nurses, irrespective of their background, education and experience. We want only those waived LPN's who are qualified to serve as shift supervisors.

We propose that Section 1861(j) of the Social Security Act, as amended, be amended by adding at the end of said sub-section the following new paragraph:

"In determining the qualifications of a licensed practical or licensed vocational nurse to serve as a shift supervisor in tended care facilities, or any similar duty under Title XVIII or Title XIX hereof, the Secretary shall take into consideration the total education and training (including refresher and extension courses), successful completion of a standard state board examination, experience, ability and dedication to nursing as well as graduation from a state approved school or a school accredited by a recognized national accrediting body."

Mr. WATTS. Thank you very much for your statement.

Are there any questions?

Mr. ULLMAN. Mr. Chairman.

Mr. WATTS. Mr. Ullman.

Mr. ULLMAN. You did a fine job of presenting your case. Tell me is this a problem in all of the States?

Dr. CONLEY. Yes, it is, Mr. Congressman.

Mr. ULLMAN. In all.

Dr. CONLEY. You mean the problem of waived LPN's in a supervisory capacity?

Mr. ULLMAN. Yes.

Dr. CONLEY. Yes, sir. It is more serious in some than in others, however.

Mr. ULLMAN. Because the State laws treat the matter differently, is that right?

Dr. CONLEY. Because the supply is different in some States. There are more RN's, for example, in some States than in others. The proportion of RN's to LPN's is different in some States.

Mr. ULLMAN. But it is a problem.

Dr. CONLEY. It is a serious problem throughout the country, yes.

Mr. PICKENS. Congressman, you see, the waiver comes about because of the fact I will say approximately 20 years ago there was no licensure of practical or vocational nurses. Then most of the States first adopted permissive licensure, and at that time in order to be a valid provision the feeling was generally that for a year they had to waiver nurses that were not graduates of State approved schools, but who could pass the State examination.

Then you went into a second phase where many of these States went from permissive licensure of practical and vocational nurses to mandatory licensure, and I think you have legislation in two States this year—the only two that I can recall are Colorado and West Virginia—which are now going from permissive licensure to mandatory licensure, and because of the feeling I suppose of the legal profession they do have these so-called grandfather clauses. They are not truly grandfather clauses, but they do give candidates a year who have not graduated from a State approved school to take the State examination upon a showing of experience, background, education and this sort of thing, but in almost every instance the licensed nurse by waiver takes the same standard State examination as the graduate of the State approved school.

Mr. ULLMAN. Thank you.

Mrs. STEPHENS. Mr. Chairman. I am Mrs. Nell May Stephens from Georgia, a registered LPN. I have been working in the District of Columbia for the past 15 years.

Mr. WATTS. Madam, we have a regular order of procedure here and if you are not a witness—

Mrs. STEPHENS. If I may ask you to correct his statement—

Mrs. WATTS. Please sit down and consult the clerk at an appropriate time. Is she connected with your organization?

Mr. PICKENS. No, sir.

Mrs. STEPHENS. I would like to correct this statement.

Mr. WATTS. You don't have any right to ask any questions. Will somebody escort this lady out.

Mrs. STEPHENS. No, sir, you don't need to do that. I was examined, licensed, and registered by the State of Tennessee in 1946.

Mr. WATTS. If you want to testify before this committee you should appear before the clerk and get permission.

Mrs. STEPHENS. I would like to.

Mr. WATTS. Mr. Clerk, will you see that this lady stops interrupting the hearing?

Mr. BURKE. Mr. Chairman, may I suggest that somebody take her over to the office and show her how to apply.

Mr. WATTS. If she wants to testify we will give her time to appear before this committee.

(Mrs. Stephens' subsequent prepared statement is printed at p. 2452 of the hearing.)

Mr. WATTS. Mr. Collier.

Mr. COLLIER. Dr. Conley, at the risk of pleading ignorance in this area, what is the schooling now required for a registered nurse? Let's take, for example, a young lady who has completed her 4 years high school work. What is now required in the so-called non-waiverable cases in education to become a practical nurse?

Dr. CONLEY. The average course of study is 1 year and in two States the course of study is 18 months. Massachusetts is one of the States. But it is a 1-year course, in which time the orientation is always on the direct patient care. However, they do get a great deal of academic background as well in medical and surgical nursing, obstetrics, pediatrics, of course the basic sciences, and so forth.

Mr. COLLIER. It is either 1 year or 18 months generally?

Dr. CONLEY. One year.

Mr. COLLIER. Are the equivalency standards that are set up by the States by which the waiver is granted generally uniform?

Dr. CONLEY. No, they are not.

Mr. COLLIER. They are not uniform. What would be the number of years of experience, let's say, all other things being equal, that would be required before a nurse could receive a waiver to become eligible to take her State examination?

Dr. CONLEY. It could be as low as 2 or 3 years.

Mr. COLLIER. Two or three years.

Dr. CONLEY. Yes, sir.

Mr. COLLIER. You are aware, I am sure, of the fact that the Department of Health, Education, and Welfare is presently funding training programs for practical nurses in, well, in my own district in a high school. Since this matter never arose before I don't have the answer and will find out later, but are you familiar with these courses and do these replace what the normal schooling requirements would be for an LPN?

Dr. CONLEY. Are these the manpower programs? Is that what you are referring to?

Mr. COLLIER. Yes.

Dr. CONLEY. These prepare men and women to take the licensing exam. It is a 1-year program.

Mr. COLLIER. A 1-year program.

Dr. CONLEY. Yes. They are excellent programs also.

Mr. COLLIER. I am sure they are. I am sure that this was one of the finest programs of its nature in my district, but I am just trying to figure out with the length of the course involved in these cases whether they would be able to do the job which a full-time student working in a regular school would be able to accomplish?

Dr. CONLEY. Well, they must put in the same number of hours if we are talking about the same thing.

Mr. COLLIER. Then I would assume that these nurses who attend these schools under the Manpower Training Act that is funded by the Department of Health, Education, and Welfare would not need to secure a waiver.

Dr. CONLEY. No.

Mr. COLLIER. Just one other question. In the area of the so-called male practical nurses, I think you are probably aware of the fact that

there is a tremendous shortage of this type of help, particularly in our veterans' hospitals. This shortage has become almost critical because of the physical limitations many times of female practical nurses in moving spinal patients and so on. There are a sizable number of male nurses who are securing waivers today.

Dr. CONLEY. I am sorry I do not have the file. I do know that there are more male nurses in the schools, practical nurses, than in the schools of professional nursing.

Mr. COLLIER. Because of the shortage the Veterans' Administration is presently waiving certain requirements.

Dr. CONLEY. We have been very concerned with the graduates of the schools, the Army schools, the medical specialists, who in some States may not be licensed, you see, even on the basis of their Army course, and we have been working with the Army on this problem.

In certain States this course will be accepted for licensure, but in other States it will not.

Mr. COLLIER. Just one final question. I saw some figures perhaps as far back as 4 or 5 years ago. Presently what is the shortage of practical nurses as near as can be estimated across the country?

Dr. CONLEY. The Surgeon General's report, if I recall correctly, stated that by 1970 we would need 350,000 licensed practical nurses. We now have about 280,000.

Mr. COLLIER. Actually going up almost 100,000 in 5 years.

Dr. CONLEY. Yes; 4 or 5 years.

Mr. COLLIER. Four or five years.

Dr. CONLEY. We graduated practically 22,000 last year, 22,000 from the schools, but we are getting a great many also in by waiver. The State of Pennsylvania, for example, has a waiver period at the present time.

Mr. COLLIER. Thank you very much, Mr. Chairman.

Mr. WATTS. Dr. Conley, may I ask you one or two questions?

How many States now have licensing of practical nurses? All of them?

Dr. CONLEY. All States, 50.

Mr. WATTS. The waiver situation came about, I understand, when the States first adopted licensing because if they hadn't there wouldn't have been anybody to operate as a practical nurse.

Therefore, they had to look over those people who had certain qualifications and rather than wait for the examination they granted them a waiver when they needed them.

Do all the States continue to grant waivers now that there is a method of examination?

Dr. CONLEY. When they open up the law, when they open up the Nurse Practice Act to make certain changes in the—

Mr. WATTS. I am talking about a State that has had a law for 20 years. Do they sometimes grant waivers there, or do you have to qualify by examination?

Dr. CONLEY. When they open the law up to make changes, for example, to make the law mandatory instead of permissive, they have a waiver period; yes.

Mr. WATTS. If you have a State though that has a mandatory law, for sometime they don't write any waivers now, do they?

Dr. CONLEY. Probably not; no.

Mr. WATTS. The reason for the waiver is that you had to have somebody operate as a practical nurse at the time you put the law into effect?

Dr. CONLEY. Yes.

Mr. WATTS. And what you are saying is that HEW ought to recognize the licensing by waiver or by examination of those practical nurses that the State so recognizes.

Dr. CONLEY. Yes.

Mr. WATTS. Do all of the States have rather stringent or fairly stringent rules in conducting examinations and waivers?

Dr. CONLEY. It varies considerably between States.

Mr. WATTS. I know it is going to vary, but there is no State that just opens its doors to everybody, is there?

Dr. CONLEY. No.

Mr. WATTS. In other words, you have to have some qualifications in every State before you can get a waiver.

Dr. CONLEY. Yes; yes.

Mr. WATTS. Thank you.

Dr. CONLEY. Thank you, Mr. Chairman.

Mr. WATTS. The next witness is Mr. Thomas M. Jenkins, president of the American Association of Homes for the Aging. Come around, Mr. Jenkins. Give your name to the reporter, sir, and your title and you may proceed.

STATEMENT OF THOMAS M. JENKINS, PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING; ACCOMPANIED BY LESTER DAVIS, EXECUTIVE DIRECTOR

Mr. JENKINS. Mr. Chairman, I am Thomas M. Jenkins, an attorney, 1 Kearney Street, San Francisco, a member of the Board of Directors of the National Council on the Aging, and a member of the California Advisory Hospital Council. I am here today as president of the American Association of Homes for the Aging. I am accompanied by Mr. Lester Davis, the executive director of that association.

Mr. WATTS. We are delighted to have you. Have you a statement too, Mr. Davis?

Mr. DAVIS. No, just accompanying Mr. Jenkins.

Mr. JENKINS. With your permission, Mr. Chairman, I would like to have the remarks which I have duplicated made a part of the record and summarize them.

Mr. WATTS. Your full remarks will be made a part of the record and you may summarize them if you wish.

(The statement referred to follows:)

STATEMENT OF THOMAS M. JENKINS, PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

I am Thomas M. Jenkins, President of the American Association of Homes for the Aging. The American Association of Homes for the Aging is the national membership organization of nonprofit voluntary and governmental Homes for the Aged. It provides its members with a means of identifying and solving problems of mutual concern and thus protects and advances the interests of the individuals they serve. The Association has sprung from a genuine need for exchange

of experience, technical assistance, help with staff training and education, and representation on the national scene so that Homes for the Aged can more effectively serve the growing number of older men and women in need of residential care.

Founded in 1961 with a grant from the Ford Foundation, the Association, sponsored by the National Council on the Aging, is made up of nonprofit institutions caring predominantly for the aged and meeting licensure standards of their own community or operating under community sanction where licensure does not exist. Membership may also be granted to organizations other than Homes and to individuals who share the aims and goals of the Association.

Mr. Chairman, I should like to emphasize at the outset that we regard H.R. 5710, in general, as a worthy bill, laudable in its objectives and sound in its drafting. We note with particular satisfaction the increased cash benefits that would be provided under the bill. We can testify from our knowledge of the lives and circumstances of older people that these proposed higher benefit payments are needed.

For this reason, we endorse—in addition to the proposed general benefit increases for present and future beneficiaries—the proposed higher minimum benefits and the increase in special payments to certain people who are age 72 or older. We also endorse, in principle, the proposal to require all States to meet the full need of individuals found eligible for public assistance payments under the standards determined by the States themselves.

As spokesman for an organization of public and voluntary, nonprofit institutions housing and serving elderly men and women—of all faiths, creeds and colors—I will address my comments especially to the provisions of H.R. 5710 dealing with Titles XVII and XIX of the Social Security Act that authorize health insurance benefits and medical assistance to the needy aged.

As a responsible group we share, with government, concern for the spiraling costs of health care. Moreover, we are eager to insure that costs for such care should not become prohibitive. Therefore we welcome the provisions in this bill to allow adequate reimbursement at every level of service appropriate to the need of the older person. Thus, assurance can be given that the older person receives the most appropriate kind of care, in the most appropriate facility, at a minimum of cost to the individual and to the government.

Our member organizations provide long-term care for the residents of their institutions—long-term care in every sense, residential, spiritual, social, economic and medical. H.R. 5710 does not attempt to meet the substantial and growing need for long-term care of these types among the older men and women of the nation. We recognize that. However, the provisions of H.R. 5710 and of the statutes it seeks to amend do touch, at certain points, the programs of long-term services for the elderly that are administered by our member institutions. It is to these points of contact and possible future contact that I wish to direct my testimony.

The benefit provided under Title XVIII for post-hospital care in an “extended care facility” (ECF) is one important point where the Social Security Act does impinge upon the operations of our member institution, and I regret to report that the contact at present is inadequate and ill-fitting and thus not working smoothly to the benefit of the elderly people whom all of us wish to assist.

Many of our member institutions have qualified as “extended care facilities,” under the language of the statute and the regulations issued by the Secretary of Health, Education, and Welfare. For the most part, these ECF’s have certain wings or wards or buildings—part of their total facility and program—that qualify as FCF’s. In operation, however, the Medicare program regards our member institutions no differently than a “skilled nursing care facility,” which has the tragic effect of eliminating the eligibility of many of our residents for substantial Medicare benefits to which they would otherwise be entitled.

In a Home such as Douglas Gardens in Miami, Florida, for example, an otherwise qualified resident may be transferred to a qualified hospital and from the hospital back to Douglas Gardens, where he can receive skilled nursing home care. The hospital is reimbursed for its reasonable costs of providing this care, as is Douglas Gardens, for the provisions of extended care. Only the patient is the loser under the present law and regulation.

For the sad fact is, Mr. Chairman and members of the Committee, when the patient is discharged from the skilled nursing home wing of Douglas Gardens and returns to his residential quarters, where he may have been living for many

years, he is not regarded by the administrators of Medicare as having changed his status in any way. He is considered to be remaining in the ECF—since the entire institution has qualified for this status—and hence he never has an opportunity to begin a new “spell of illness” and thus acquire eligibility for additional ECF and hospital benefits, should he need them.

I am confident that the situation I describe—which I am informed is occurring with considerable frequency in some of the institutions for whom I testify today—is not a result intended or envisioned by the Committee when it drafted the Medicare statute in 1965. I cannot say whether it is necessary to amend the statute to permit the Social Security Administration to rectify this situation, or whether this can be achieved by administrative action. Nevertheless, I do call to the attention of the Committee the fact that, for whatever cause, many, many people are failing to qualify for an additional “spell of illness,” merely because they have the good fortune to reside in a high quality, nonprofit Home for the aging which has qualified as a provider of skilled nursing care under the Medicare law. This inequity must be rectified so that an aging person receiving high caliber nursing care NOT be disenfranchized.

Next, Mr. Chairman, I wish to endorse Section 205 of H.R. 5710, which would permit States to offer the broadest range of appropriate resources, including skilled nursing home care specifically for those who need it, as well as other services provided by or in other institutions, or in the individual's own home. Although the language of the bill is permissive with respect to the States, not mandatory, I am confident that this proposed provision would be effective in reducing any possible over-utilization of skilled nursing care beds that might be occurring.

Finally, Mr. Chairman, because of our concern for the non-interruption of services needed by the older person, I should like to point out that Titles XVIII and XIX are not dovetailed as smoothly as I believe the Committee originally intended. In my judgment, with respect to the quality of services rendered and the method of computing reimbursement for services provided by ECF's, the two Titles should be so designed as to assure realistic payments for this continuity of care. Moreover, it is our firm conviction that all certified providers of service should be reimbursed by the same formula. Discriminatory rates to voluntary nonprofit Homes, as compared to proprietary homes and hospitals, create an inequity which defeats the goals of the program. The States may, if they wish, adopt the same method of calculating their reimbursement of ECF's under Title XIX as they do under Title XVIII, but this is not mandatory, as you know. States must reimburse hospitals on the same basis under both programs, but they need not follow this sound approach with respect to ECF's, nor do all States.

I submit, Mr. Chairman and members of the Committee, that ECF's should not be reimbursed either more or less fully under Title XVIII than under Title XIX for what are essentially identical services rendered to patients who differ only with respect to eligibility for a particular mode of payment, not in terms of age, diagnosis or any other significant way.

The American Association of Homes for the Aging has always been in the vanguard of supporting the highest standards of care. We applaud the upgrading of care which has been possible as a direct result of implementation of Title XVIII. We support and endorse this continued upgrading under Title XIX. Programs under Title XVIII have already had and will be having a continued effect on upgrading these standards—they will have a parallel impact on care provided under Title XIX. It is obvious, therefore, that with lower and inadequate funds this care will be seriously hindered.

In conclusion, Mr. Chairman and members of the Committee, I appreciate the opportunity of bringing these matters to your attention in behalf of the American Association of Homes for the Aging, and I shall be pleased to answer such questions as you may wish to ask.

Mr. JENKINS. Mr. Chairman, our association is concerned with the growing needs of the growing number of elderly who are in need of residential care and I would like to state at the outset that we regard this bill, H.R. 5710, as a worthy bill, laudable in its objectives, and sound generally in its drafting.

We note with particular satisfaction the increased cash benefits that would be provided under the bill. We can testify from our knowledge

of the thousands of people in our homes. We can testify from our knowledge of the lives and circumstances of the older people in our homes that the proposed higher benefits under this bill are sorely needed.

For this reason we endorse, in addition to the proposed general benefit increases for present and future beneficiaries, the proposed higher minimum benefits and the increase in special payments to certain people who are age 72 or older.

We also endorsed the proposal which was amplified by Secretary Gardner in his statement to you which would require all States to meet the full need of individuals found eligible for public assistance payments under the minimum standards as determined by the States themselves.

I would like, however, to address my comments particularly to those portions of the bill that relate to authorization of health insurance benefits and medical assistance to the needy aged.

As a responsible group we share, with others, the concern for the spiraling costs of health care. Moreover, we are eager to insure that costs for such care should not become prohibitive. Therefore, we welcome those provisions in this bill which allow adequate reimbursement at every level of service appropriate to the needs of the older person.

Thus, assurance can be given that the older person receives the most appropriate kind of care in the most appropriate facility at a minimum of cost to the individual and to the Government.

As I have indicated earlier, our organizations are concerned primarily with long-term care for residents in their institutions. We recognize that this bill does not attempt to meet the substantial and growing needs for this type of long-term care.

However, our concerns are that the provisions of this statute and the statutes it seeks to amend do touch at several points the programs of our institutions and it is to these points that I wish to direct my testimony.

The benefit provided under title XVIII for posthospital care in an extended-care facility is one important place where the Social Security Act does impinge upon the operations of our member institutions and I regret to report that the contact at present is inadequate, ill fitting, and is not working smoothly to the benefit of the elderly people whom we wish to assist.

Many of our member institutions throughout the United States have qualified as extended-care facilities under the language of the statute and of the regulations issued by the Secretary of Health, Education, and Welfare.

For the most part these extended-care facilities have certain wings or wards or buildings, parts of their total facility and program, that qualify as an extended-care facility. In operation, however, the medicare program regards our member institutions no differently than a "skilled nursing-care facility" which has the tragic effect of eliminating the eligibility of many of our residents for substantial medicare benefits to which they would otherwise be entitled.

In a home, for example, such as Douglas Gardens in Miami, Fla., an otherwise qualified resident may be transferred to a qualified hos-

pital and from the hospital back to Douglas Gardens where he receives skilled nursing-home care. The hospital is reimbursed for the reasonable costs of providing this care, as is Douglas Gardens, for the provision of extended care.

Unfortunately, only the elderly resident is the loser under the present law and regulations, for the sad fact is, Mr. Chairman, and members of the committee, as we understand the regulations presently promulgated, when the elderly person is discharged from the skilled nursing wing of Douglas Gardens and returns to his residential quarters, where he may have been living for many years, he is not regarded by the administrators of medicare as having changed his status in any way. He is considered to be remaining in an extended-care facility since this institution has qualified for that status, and hence he never has an opportunity to begin a new spell of illness and thus to acquire eligibility for additional extended-care facilities or extended hospital benefit.

I am confident that this situation was not the result intended or envisioned by this committee when it drafted the medicare statute in 1965. I cannot say whether new amendments are required to the Social Security Act or new regulations.

We do call to the attention of the committee these inequities and ask that they be rectified. I would like next, Mr. Chairman, to address myself to one section, 205, which would permit the States to offer the broadest range of appropriate resources, including skilled nursing-home care specifically for those who need it, as well as other services provided by or in other institutions, or in the individual's home.

Although the language of section 205 is permissive with respect to the States and not mandatory, we are confident that this proposed provision will be effective in reducing any possible overutilization of skilled nursing care beds that might be—we suspect is—occurring.

Finally, Mr. Chairman, because of our concern for the noninterruption of services needed by the older person I should like to point out that titles XVIII and XIX are not dovetailed as smoothly as I believe this committee originally intended. In my judgment, with respect to the quality of services rendered and the method of computing reimbursement for services provided by extended-care facilities, these two titles should be so designed as to assure realistic payments for this continuity of care.

Moreover, it is our firm conviction that all certified providers of service should be reimbursed by the same formula. I know that you had testimony yesterday by Mr. Charles Wick who indicated to you some of the problems and inequities in the present reimbursement formula. We subscribe to that portion of his testimony that relates to the factors which ought to be considered in connection with that reimbursement.

Discriminatory rates, we contend, to voluntary homes, as compared to proprietary homes, create an inequity which defeats many of the goals of this program. We suggest to you, Mr. Chairman, that extended-care facilities should not be reimbursed either more or less fully under title XVIII than title XIX for what are essentially identical services rendered to patients who differ only with respect to eligibility for benefits, not in terms of age, diagnosis, or in any other significant way.

The American Association of Homes for the Aging has always been in the vanguard of supporting the highest standards of care. We applaud the upgrading of care which has been possible as a result of implementation of title XVIII. We support and endorse this continued upgrading under title XIX. Programs under title XVIII have already had and will be having a continued effect on upgrading of these standards. They will have a parallel effect on the care provided under title XIX.

It is obvious, therefore, that with lower and inadequate funds this care will be seriously hindered.

I have one further comment, Mr. Chairman and members of the committee, that is not covered in my duplicated remarks, and that relates to that area of H.R. 5710 which concerns itself with the mandatory funding of depreciation and the mandatory planning or distribution of depreciation based up a statewide health plan.

In principle it is difficult for any national organization to quarrel with either funding of depreciation or planning. In practice, however, we would suggest to you that there are some major difficulties with the suggestions as made by this bill. The funding of depreciation on a voluntary basis is an excellent idea and we commend it to all of our members.

We recognize in fact, however, that this is an impossible thing until such time as the reimbursement formula itself is so geared as to cover all of the costs and to include some provision for the amortization of debt. It would be impossible for our homes and hospitals to survive under the proposals as made.

Secondly, as to planning, we support fully voluntary planning on an area or geographical basis. As I indicated at the beginning, I am a member of the California Hospital Advisory Council which is concerned with the preparation of the State plan in that State. We would find it impossible, Mr. Chairman, to include the thousands of proprietary and hundreds of nonprofit facilities within our State plan. We would find it impossible to handle this depreciation factor and the expenditures of funding depreciation as proposed by H.R. 5710.

We think the cost of such a planning activity would far exceed all of the values to Government of mandatory planning.

Thank you, Mr. Chairman.

Mr. WATTS. Thank you, sir. We appreciate your appearance.

Are there any questions?

Mr. COLLIER. Just one, Mr. Chairman. I am sorry, but it is something I don't want to pass up here.

Mr. Jenkins, you say you applaud the upgrading of care which has been made possible as a result of implementation of title XVIII, and then go on to say that it has a parallel impact under title XIX.

When you speak of upgrading, what specifically do you refer to?

Mr. JENKINS. Well, Mr. Collier, we are referring to the standards that have been set under title XVIII which have resulted in requirements for accreditation by our homes with the resultant necessity for many areas of upgrading of their care. We feel that this has been a real value to the industry as a whole and to the people that they serve.

Mr. COLLIER. I was hoping that is what you meant and not an expansion because, as you well know, we are in very serious trouble in

funding title XIX under some of the programs as a result of the very ambitious program that was adopted by the State Legislature of New York.

I am pleased that that is what your reference was to.

There is just one other thing, if I may. You say in your statement that you welcome provisions of the bill to allow adequate reimbursement at every level of service appropriate to the need of the older person, and I think we could all agree on that, recognizing at the same time, however, that in many of these instances, because there is no test involved at all for people past 72, that there are many, many people in this age bracket who are economically totally self-sufficient and in fact in many instances have sufficient wealth, let's say, to provide this care in that twilight zone in their life that really are getting assistance in these programs who do not need it from the standpoint of economics, and I have some very serious misgivings in this area because of the fiscal problems we are confronted with in the overall social security trust fund obligations on a current and long-term basis.

Mr. JENKINS. Mr. Collier, we think that the provisions of the bill or of the statement that we made would assist in the determination of the type that you are talking about. We are suggesting and we say appropriate facility and appropriate kind of care, that we do not believe in an overutilization of medical care, that there is or should be means by which persons can be transferred from one level of care to a lesser level of care, that this can be paid for rather than continuing to overutilize, as we suspect and we know is happening in some of our facilities because there is at present inadequate provision for payment for the lower level of care.

Mr. COLLIER. In that regard I couldn't agree with you more. Thank you, Mr. Chairman.

Mr. WATTS. Thank you, gentlemen.

Mr. JENKINS. Thank you, Mr. Chairman and members of the committee.

(The following telegram was received by the committee:)

NEW YORK, N.Y., April 17, 1966.

Representative WILBUR MILLS,

Chairman, House Ways and Means Committee, Washington, D.C.:

On March 10 I testified on H.R. 5710 before the House Ways and Means Committee on behalf of the American Association of Homes for the Aging the national membership organization of nonprofit voluntary and governmental homes for the aging. I should now on behalf of the association express our vigorous support and endorsement of section 127 of H.R. 5710 which includes podiatrists services under the supplementary medical insurance program. Our member homes which care for several hundred thousand elderly persons know at first hand of the vital importance of professional foot care has in enhancing the mobility, sociability and physical and emotional health of elderly persons. Indeed, in many cases podiatry care means the difference between freedom to ambulate and virtual immobilization. We, therefore, urge that podiatry services as provided in section 127 be made compensable under the medicare program.

THOMAS M. JENKINS,

President, American Association of Homes for the Aging.

Mr. WATTS. The next witness is Dr. Arthur H. Brayfield, executive officer, American Psychological Association.

If you will identify yourself Doctor, we will be glad to recognize you.

STATEMENT OF DR. ARTHUR H. BRAYFIELD, EXECUTIVE OFFICER, AMERICAN PSYCHOLOGICAL ASSOCIATION, ACCOMPANIED BY DR. JOHN J. McMILLAN, ADMINISTRATIVE OFFICER FOR PROFESSIONAL AFFAIRS; AND CHARLES HALPERN, CHIEF LEGAL COUNSEL

Dr. BRAYFIELD. Thank you, Mr. Chairman.

Mr. WATTS. Who accompanies you, Doctor?

Dr. BRAYFIELD. I am accompanied today by Dr. John J. McMillan, our administrative officer for professional affairs, and Mr. Charles Halpern, representing Judge Thurman Arnold, APA's chief legal counsel.

Mr. WATTS. We are delighted to have you.

Dr. BRAYFIELD. Mr. Chairman and members of the committee my name is Dr. Arthur H. Brayfield. I am executive officer of the American Psychological Association, which has its headquarters office in its new building at 1200 17th Street NW., Washington, D.C. Our 25,500 members include 85-90 percent of the psychologists in this country who are eligible for membership.

SUMMARY OF STATEMENT

The "revolution in health care," stimulated by medicare legislation, involves three key issues: (1) development and utilization of knowledge; (2) organization and delivery of services; (3) availability of qualified manpower.

The present medicare legislation and regulations impose undesirable constraints on the delivery of mental health services and add unnecessary costs by requiring that the services of psychologists be "incident to a physician's services."

The public interest is not served by this requirement. It restricts the patient's direct access to services and adds to the cost. It curtails already limited sources of help. It contradicts earlier congressional policy as, for example, embodied in the community mental health centers legislation.

This is a deficiency in the medicare legislation. It should be remedied in H.R. 5710.

The historic 89th Congress, in one of its most notable in a long list of achievements, established the right of the elderly people of America to adequate health care by the passage of the medicare legislation. And the executive branch moved swiftly and effectively, with the help of the health professions, to make this program a reality. We applaud these accomplishments of the Federal Government and of the professions and service institutions involved.

This legislation and this program form the core of what Look magazine this week calls the "revolution in medicine." For health professionals and citizens alike, the present challenge is to evolve a pattern for the delivery of health services which will insure that high quality health services are available to all citizens in all parts of the country. Key issues for medicare and other health legislation are the development and utilization of knowledge, the organization and delivery of services, and the availability of scarce qualified manpower.

I appear here today on behalf of the American Psychological Association to focus your attention on one aspect of the problem—the delivery of mental health services.

Our fundamental proposition is that the present medicare legislation and the accompanying regulations impose an undesirable and unnecessary constraint upon the delivery of mental health services to patients and upon the fullest and most economical utilization of mental health manpower.

I will suggest further that the present provisions contradict the intent and practice of other Federal mental health legislation. My brief discussion is primarily in reference to title XVIII, part B, Social Security Amendments of 1965.

PSYCHOLOGY AS AN INDEPENDENT PROFESSION

The defects which we find in the present law and regulations arise, as we perceive it, from the fact that two independent but equally well-qualified professions, psychiatry, and psychology, offer very similar and frequently identical services to the public.

I shall not take your limited time here to discuss either the validity of this fact or its general implications; instead, I respectfully request permission to enter into the hearings record at this time the analyses of two knowledgeable physicians as follows:

First, "A Critical Look at Professional Education in the Mental Health Field" by a psychiatrist, Dr. Allen S. Mariner, which will appear in the April 1967, *American Psychologist*, and second, "The Physician and the Clinical Psychologist: A Comparison of Their Education and Their Interrelationship" by the chairman, Committee on Medical Education, Oregon Medical Association, Dr. Herman A. Dickel, which appeared in the January 31, 1966, issue of the *Journal of the American Medical Association*.

I ask now that these documents be received.

MR. WATTS. Without objection, they will be made part of the record. (The information referred to follows:)

[Reprinted with permission from the *Journal of the American Medical Association*, Jan. 31, 1966]

THE PHYSICIAN AND THE CLINICAL PSYCHOLOGIST—A COMPARISON OF THEIR EDUCATION AND THEIR INTERRELATIONSHIP

(Herman A. Dickel, M.D.)

As is well illustrated in the reports that appear from time to time,¹ there is an increasing enlargement in the number of people, disciplines, and interested groups who involve themselves in the general field of health. These individuals and their groups, known as the paramedical groups, are often inadequately known to the physician. A more clear and sound understanding of these groups should exist. There are obvious basic differences between these groups and the medically trained physician. Yet, with time and advancements in the knowledge of health and disease, there is a point at which the various groups do approximate one another in their training and must necessarily overlap in the services that they render the patient, his illnesses, and his community.

GAPS IN THE REALM OF RESPONSIBILITY

One of the areas of health presently receiving most careful consideration is that of mental health. During the past century, for several reasons, the medical profession has not shown the same interest in mental health as it has in physical

health. Medical problems were considered to be only those "organic." Anything found to be other than specific pathological change was considered in the "mental" field. This, to the average physician, was considered outside his realm. Admittedly, some physicians went so far as to specialize in "psychiatry," but these specialists were not easily accepted by other physicians and the public. Quite naturally, with this area of health left essentially unattended and sorely in need of assistance, there have been a number of other disciplines entering this area who did have the interest, resources, and motivation to do all they could. They have necessarily filled some of the gaps. Many contributions have come from their ranks and the resources available from their body of knowledge.

Within the past decade, however, the interest of the medical profession for the mentally ill has returned. Whether or not this return was fostered by the appearance of the tranquilizer drugs remains to be seen, but certainly the age of the tranquilizer has materially altered the physicians' interest in, and responsibilities for, the patient who has emotional, mental, or psychological illness.² This is reflected in the field of continued medical education which gives more thoughtful attention to courses in psychiatry for the nonpsychiatric physician than almost any other.

As this occurs, as other disciplines contribute to mental health, areas of misunderstanding and concern have appeared. Problems exist related to the question of who rightfully should evaluate and treat the mentally ill person. The physician inherently, traditionally, and legally has had this duty and responsibility. Because he has left gaps in this realm of responsibility, however, others have taken over and are now accepted by the patients who are ill and by the institutions in which they are treated.

It is here that clinical psychologists and medical physicians have often found themselves in discord. Controversy, misunderstandings, and areas of inability to get along have developed quite naturally between the disciplines caring for the mentally ill. Although these are not widespread, there are specific areas of concern and specific problems that still remain to be solved.

Today, the medically-trained physician entering the mental health field finds that the clinical psychologists are there too. They, too, have an unusual understanding of, a considerable body of knowledge about, and certainly specific ideas as to what is correct for the treatment of, the mentally ill. Because of the background of their education and training, because of their preparation for clinical and therapeutic practice, and because the two groups have never really understood the difference between the medically-oriented and the psychologically-trained doctorate, these areas of misunderstanding have recently grown critical in certain areas. That these two groups overlap, that they could be valuable to each other as well as to the mentally ill person, and, therefore, that they must somehow or other learn to get along in the future, seems obvious. That this is not presently taking place in many areas is likewise obvious. As a consequence, the only people who are seriously suffering are the people in the area of mental illness, those who should be profiting beneficially from the combined efforts of both.

In the past five years, many of us have had to change our opinions considerably in regard to this whole problem. Because it has been the experience of the author to modify his opinion, this opportunity will be used to present some of the material showing the fundamental areas of variation and common interests. The paper is presented chiefly to assist others in recognizing that differences in training do exist: they are wide in some areas and extremely narrow in others. They both have certain fundamental goals. These goals are not identical, and they shouldn't be, for each discipline should serve entirely different purposes. However, the end result of each goal is eventually the good mental health of every citizen. The physician and the clinical psychologist can deny their relationship, but the two disciplines should understand one another, should be able to comfortably cooperate and yet should not at any time encroach upon each others legal, professional, and moral responsibilities, duties, or functions.

It would be the purpose of this paper to compare the training of the two disciplines showing where they are similar and vary; and how they could and do complement one another. To indicate some of the steps that will bring about more cooperation and interrelationship is a final purpose. The value of each to the other and to the mentally ill patients is, of course, the basic purpose.

For the average physician reading this paper, it would be unnecessary to go over the curriculum in the approved medical schools of the United States. However, a brief review seems in order so that those readers not physicians may interrelate it with the training and background of those in clinical psychology.

THE MEDICAL CURRICULUM

First, it should be emphasized that the student currently chosen for medical education is as carefully selected as is academically possible. Few, if any, other selection processes have quite attained this perfection. This is demanded by public attitude, by academic tradition, by legal definitions, and most important, by the inherent and deeply rooted professional commandments.

Presently, the aggregate number of class hours in an approved medical school approximates 5,400 extending over a period of four years, with from 1,300 to 1,600 hours each year.

From school to school the division of these 5,400 hours, of course, varies. They are divided in the first two years into the basic sciences, namely, anatomy, bacteriology, biochemistry, clinical pathology, medical psychology, pathology, pharmacology, and physiology. These courses will total close to 2,500 hours. This includes the individual dissection of a cadaver and the full working knowledge of anatomy. It includes some 250 hours of biochemistry, the same of physiology and bacteriology. There is half again as much in basic pathology of disease. Courses in pharmacology, psychology, and clinical pathology may total as little as 50 hours, or run in excess of 250.

The two years in clinical work in medical school is divided, with major emphasis in the medical and surgical branches. There are courses in medicine, psychiatry, surgery, ophthalmology, obstetrics and gynecology, pediatrics, radiology, public health, etc. In a department of medicine alone there will be over 1,000 hours spent. It will vary from as little as 36 hours of work in radiology. The preponderance of hours will obviously be devoted to those courses where the intimate examination of patients, the diagnosis of each disease entity following the use of every modern sensitive technique or device, and a complete review of treatment will be stressed. Throughout the four years adequate time is devoted to emphasizing courses which treat the patient as a whole, with the emotional, psychological, and sociological aspects of each disease being integrated with the biochemical, physiological, and pathological aspects. The modern medical school's education requires the student to see illness and health in the cultural setting, as a part of the family problems. Besides relating their own academic courses to the disease, the student must interrelate the sociological and family background to the cause of the disease so that the treatment can be from the broadest point of view.

Beyond the four years of medical school, the completion of which brings a doctorate of medicine degree, there is at least one full year of internship in an approved hospital. During the internship there is a continuation of training on a less academic level involving more supervised opportunities for the student to render medical service to patients with many medical and surgical problems.

At the completion of an internship, most states in this country permit the individual physician to be examined for licensure. On passing he receives a medical license to practice in that state, providing he has also a "basic science" certificate which is almost as important, for it designates those recognized by law as a part of the "healing arts." The fulfillment of the entire medical education will be the receipt of this license which bestows on the physician legal, as well as professional, responsibilities in the practice of medicine. As a physician, the profession will make him personally, ethically, and morally responsible for the patient.

The present philosophy of medical education and the modern medical curriculum, together with the graduate and continued medical education programs, are still for the most part based on the thinking of Abraham Flexner, when he said:

"The medical school cannot expect to produce fully trained doctors; it can at most hope to equip students with a limited amount of knowledge, to train them in the method and spirit of scientific medicine, and to watch them with a momentum that will make them active observers, learners, readers, thinkers, and experimenters for years to come. . . . The general arrangement of the curriculum, if sound, can make this task a bit easier, or if unsound, a bit harder; but in general much more—very much more—depends upon teacher and student and on curriculum mechanics or teaching devices."³

A NEWER DISCIPLINE

The clinical psychologist, the individual and his work, is largely an unknown area to many a physician in medicine. This is lamentable, but not an irreversible, situation. It is hoped that this introduction will encourage the physician to

further acquaint himself with the clinical psychologist—his work and his present position in health fields. We would leave to this physician the decision as to the relationship that will exist between himself and the clinical psychologist in the future.

Clinical psychology, as defined in a report by a committee in 1947—

“seeks to acquire systematic knowledge of the human personality, and to develop principles and methods by which it may use this knowledge to increase the mental well-being of the individual. Clinical psychology is considered by some both a science and an art, calling for scientific rigor tempered by personal and social sensitivity. It is directed toward three major areas: diagnosis, therapy, and research.”⁴

It is not confined just to “mental illness.”

The educational background of the clinical psychologist, with a degree of PhD, is somewhat comparable in academic and clinical training to the physician in general practice. The American Psychological Association's “standards committee” recommends that the clinical psychologists be recognized as such only if he has a doctorate.

To be admitted for training for this doctorate degree in an approved center, there are requirements similar to those for a medical school. Specific consideration is given to intellectual ability, the character makeup, the insights, the sense of responsibility, the tact, the integrity, etc., as is given to a person preparing for medicine. At the moment, however, it would appear that medical schools uniformly choose their students on a slightly more exacting basis, because of aptitude tests, admission committees, and age-old perfectionism of the profession.

In the undergraduate academic courses there is training in psychology, the biological and clinical sciences, mathematics, courses in education, some in the social and cultural sciences, in literature, and in language. These courses are essentially the equivalent of premedical courses, except the core is more a “cultural-psychosociological” point of view with emphasis on “behavior,” rather than the traditionally medical orientation in which a “biochemical-biological-organic” point of view is the basis of studies from which students are chosen.

The graduate training programs in approved academic centers consists of four years for the doctorate. These four years consist particularly of additional training in general and specific psychological courses, training in the psychodynamics of behavior, and in diagnostic methods of all sorts. There are courses in testing and diagnostic work which will be applicable to the various areas in which the psychologist may work. Training in the therapeutic programs are aimed toward specific remedial aspects of special disabilities. There are courses in the technique of guidance and counseling and in “personality therapy.” In recent years, courses have been developed for training in the techniques of group therapy. Presently, much of the work of a clinical psychologist is in many areas of research, and specific training is directed toward methods, techniques, etc, in broad areas.⁵

Those schools graduating clinical psychologists relate their work to the other disciplines in the health field. There are survey courses in the physiological sciences, introductory courses to medicine, to social organizations, and social pathology, and courses in culture and its relationship to personality. There are courses that relate the graduating student to the several fields in which clinical psychology can be applied. During the third of the four years in the graduate school the student will have a full year of internship. Then the student returns for his fourth year in the academic setting, the completion of which leads to his doctorate degree. Some few schools now consider a fifth year after the doctorate degree. At present, a handful of schools give postdoctorate courses to prepare the clinical psychologist for specific work in a particular clinical or research setting.⁶⁻⁷ On the completion of the four years, the clinical psychologist is granted a PhD. This will permit him to do most of his work, depending on the area and its statutes.

There are no uniform state laws at present governing the manner in which a clinical psychologist will dispense his professional ability. In some states he is certified and controlled by some legal definitions. Many states express no concern and allow unskilled semiprofessionals to do anything under a label of “clinical psychologist,” until even the genuine are embarrassed. Certification is desirable in order to control use of the expression “clinical psychologist.” No state has as yet seen fit to enforce or encourage psychologists to take “basic sci-

ence exams," even though they "practice" that which many consider a healing art.

At present, the following principles are set forth as the standard educational background of the clinical psychologist:⁴

1. That a clinical psychologist must first of all be a psychologist.
 2. That the training be as vigorous and intensive as that for any of traditional doctorates.
 3. That preparation be broad, and that professional goals be the end result.
 4. That the requirements meet six major subjects as noted above in the training program.
 5. That the program in these courses should concern itself mainly with basic courses in principles rather than multiple course techniques.
 6. That courses should be scrutinized regularly for their content and judged carefully.
 7. That the specific program of instruction should be organized around a careful integration of theory and practice.
 8. Through all four years of graduate work the student should have contact direct and indirect with clinical material.
 9. That the student through all four years should have contact with normal material.
 10. That the general atmosphere of the course of training should be to encourage the increase of maturity, the continued growth of the desirable personality characteristics in the individual psychologist.
 11. That a distinct weakness in the training of psychologists compared with that of physicians and social workers has been the lack of sufficient feeling of responsibility for patients and clients. The program should do everything to offset this and relate the psychologist to the individual.
 12. There should be representatives of related disciplines in the teaching of the clinical psychologist.
 13. Research should be emphasized, but should not be the only thing emphasized.
 14. "In addition to the research applications of the data he should become sensitive to their social implications; he must acquire the ability to see beyond the responsibility he owes to the individual patient, to those which he owes to society. Medicine has developed a code which is admirable so far as concerns responsibility to the individual patient, but has paid relatively less attention to the other type of responsibility. It would be the hope that the psychologist will gradually acquire more of the medical attitude toward the individual patients that develops a high degree of social responsibility as well."
- At the present time there are approximately a thousand new clinical psychologists obtaining their degrees each year.⁵ About 35% will practice clinical psychology.⁶ Since 1920, approximately 14,000 psychologists have obtained their doctorate in this country.⁷ This is not a large number compared to those in medicine, but their annual addition to clinics, hospitals, and staffs dealing with mental illness has been noticeable, since they enter a field which has not enjoyed the attention and a sense of responsibility from the physician. The sudden interest that both have developed toward mental illness in recent years brings the two disciplines sharply into contact. Here medical and paramedical groups need to enjoy the understanding of one another. Their individual status must be understood by all if conflict is to be avoided.
- The physician requires from five to six years beyond undergraduate school to be ready to practice. Essentially only four years of graduate study are now required for those in clinical psychology. From the standpoint of time alone, the educational background of the clinical psychologist is a full year less than the physician in general practice. As noted, the college background approximates the same level. Some schools are pressing for the clinical psychologist to have six years for the doctoral training.⁸

A DIFFERENCE IN ORIENTATION

Medicine and medical education still inherently approaches the ills and disorders of man from an "organic" point of view, believing man to be a biological entity in which human behavior is not yet fully accepted as a medical responsibility. Psychosociological factors are indeed considered, but the orientation of modern medicine is still reluctant to go much beyond the philosophy of "disease means pathology."

With this basic orientation, medicine understandingly has difficulty in relating its academic equivalents to that of the clinical psychologist whose training and graduate school curriculum is largely in the psychosociological-cultural field, in which behavior and the betterment of human life is emphasized.⁶ Within recent years, however, basic physiology, neurophysiology, and increasingly larger number of hours in neuroanatomy, and introductory courses to both medicine and psychiatry have been included as part of the psychologist's training. Although at present one would have difficulty equally comparing the two disciplines, nonetheless one can foresee the time approaching when some will consider that equivalent backgrounds in training do exist.

It would appear, then, that in the students chosen, and in their college academic training, medical and psychological backgrounds are fairly equal. At present, however, because of the age and the years of solidifying the profession, the medical schools and the postdoctorate training of the physician seems to point to a more distinctive position of the medical training. This is not to be taken as depreciating the training of the younger profession.

INTERDEPENDENCE AND MUTUAL RESPECT

Mental illness has been comprehended with difficulty. Only recently have physicians realized that "psychosomatic" illness is indeed one of their responsibilities and that to pass it off with the remark, "there is nothing physically wrong with you," is antiquated and detrimental.¹⁰ Other mental illnesses must be a part of medical practice also.

Admitted mental illness may not in all instances be a "disease," as defined by a physician. Nonetheless, the patient and his family look to the physician to offer a cure, or at least some direction for help. Failure to do so is hazardous. Modern attitudes toward medicine may be related to this past failure.

It is in this area that the clinical psychologist offers help to the physician. His background and trainings are designed not to "cure disease," but to render professional service in the "diagnosis, therapy, and research" of many problems including disease, disorder, and discomfort of humans.⁵ These capable people have entered a field to which they can contribute, for like the anatomist, the physiologist, the pharmacologist, and others, they offer both the physician and the patient an approach so necessary in certain conditions. They have, and can, contribute to the research on behavior and emotions, the psychology of patients. Therapeutic programs based on this orientation will alter the effect of "behavior factors" on many diseases. This is medical psychology.⁷ It is, and will be, increasingly more important.

As Dr. Thomas Durant recently said,¹¹

"There should be no neglect however in medicine or in other scientific disciplines of two highly important endeavors. The first of these is an attempt to close the gap between the appearance of important new knowledge and any practical application it may have to the problems of life (adequate post-graduate education), and secondly an effective blending of the new knowledge with that which is still of value in the old."

This paper is not to be taken as an appeal for the inclusion of the clinical psychologists (as such) directly into medicine. Neither medical or psychological advocates desire nor would either profit by such a move. Rather this paper is to urge the physician to become acquainted with and understand the field, the interests, and the abilities of the clinical psychologist. It is hoped, too, that the clinical psychologist will similarly respond.

We are in an era when medicine is being forced to undergo major changes in direction and in philosophy. The individual patient *as a person* becomes increasingly more important than his disease. The effect of his behavior pattern, his emotions, and his "psychologic state," on the etiology of each disease is now paramount. To aid and to broaden the physician's knowledge in this area can be the psychologist's task as an able and cooperative partner on a team. Many psychiatrists have so learned. Those in general medicine and other specialties may follow.

But in so doing, the physician is asked to recall the statements of the Committee on Relationships of Medicine with Allied Health Professions and Services¹ of June 1960. It stated so succinctly that physicians and other scientists must recognize that those with PhD degrees have fitted themselves for a different role than the physician, *and physicians must respect this.*

To fully respect this difference, the committee believes there is need for greater recognition by physicians that allied scientists have developed their own academic

curricula leading to advanced university degrees in distinct disciplines of science quite independently of the medical profession. They have developed intraprofessional, voluntary means to maintain and advance professional competence; they have initiated qualifying boards for recognition of this competence by their peers, and they have established their own scientific societies with suitable credentials for membership. As members of separate sciences, individuals, with Ph D degrees contribute essential skills and knowledge not only to the medical profession, but additionally to general education, industry, agriculture, and other fields.

The critical aspect of the problem, however, would appear to be in the area of properly defining and respecting the areas of activity and responsibilities of these scientists in caring for or treating patients. Historically, morally, ethically, popularly, and legally, society and patients have always given the ultimate responsibility for patient care to the licensed medically trained physician. In the final interest of the patient and the public, all other scientists, when contributing to this patient care, have recognized and respected this position of medicine. Until laws change and customs vary, this must continue. But there must be mutual respect not only for the different abilities and special qualifications of the scientists by physicians, but also concomitant recognition of the interdependence of scientists and physicians in promoting health.

As J. S. Gray, PhD, MD, a physician and basic scientist, noted, there are areas in medical education, research, and care—

“where neither medical training alone nor PhD training alone confers (the needed) competence; in these areas both groups must seek understanding and achieve a cooperation which will further the best interests of the patient.”¹

During the centuries that the profession of medicine has matured and mellowed to its present position, it has known many other disciplines which have sought to affix themselves to the practice of medicine and to the care of patients. Medicine has conscientiously dealt with each, adding from time to time such others as the physiologist, the surgeon, etc, giving each the place they have attained in the development of their discipline. Through these centuries medicine has needed to most properly and correctly relate itself to the patient, to the public, and to other disciplines as well as to its own individual members. Centuries of development have culminated in the epitome of professional standards known as “medical ethics,” a code adhered to religiously by all physicians rendering service in all patient-physicians relationships.

Medicine is energetically and wholesomely adding mental illness to the family of human miseries for which it assumes responsibility and furnishes care. At the same time it finds this new and younger discipline, clinical psychology, ready and capable of contributing a great deal. Interrelationships must take place. This is so important for the future of each and for the mentally ill patients for whom each discipline has a bounden duty.

In this new interrelationship medicine has so much to contribute and offer another discipline. Its knowledge of interprofessional, as well as intraprofessional, relationships is steeped in the wisdom of ages. As a profession, then, medicine must, as Robert Throckmorton (then legal general counsel of the AMA) recently stated: “Teach and guide these groups to understand and appreciate the value of the essentials of being ‘professional.’”¹² The patient, the profession, and the public are indeed protected by these essentials, but most important, the continued growth and maturation of each discipline is most firmly assured.

That clinical psychology has a place beside and within medicine in the “diagnosis, therapy, and research” of many human disorders is accepted and encouraged. But each individual physician must study and acquaint himself with the body of knowledge and the individuals who compose this newer discipline. Only by determining for himself the capacity of this new group to be “professional,” can the individual physician decide how this newer group can align with him and assist in the doctor-patient relationship for the future.

REFERENCES

1. McKEOWN, R. M. (chairman): Final Report of the Committee to Study The Relationships of Medicine With Allied Health Professions and Services, adopted by AMA House of Delegates, June 16, 1960, *AMA House of Delegates Proceedings*, 1959-1960, pp. 23-40.
2. DICKEL, H. A.: The Impact of Tranquilizers on Medical Practice, *J Neuropsychiat* 5:438-439 (Oct) 1964.
3. FLEXNER, A.: *Medical Education*, New York: MacMillan Publishing Co., 1925.
4. SHAKOW, D.: et al: Recommended Graduate Training Program in Clinical Psychology: A Report of the Committee on Training in Clinical Psychology of the American Psychological Association, *Amer. Psychol* 2:539-558 (Dec) 1947.

5. SUNDBERG, N. D., and TYLER, I.: *Clinical Psychology*, New York: Appleton-Century-Croft, Inc., 1962.
6. VANCE, F. L., and MACPHAIL, S. L.: APA Membership Trends and Fields of Specialization of Psychologists Earning Doctoral Degrees Between 1959-1962, *Amer Psychol* 19:654-658, 1964.
7. MATARAZZO, J. D.: A Post-doctoral Residency Program in Clinical Psychology, *Amer Psychol* 20:432-439 (June) 1965.
8. HERMAN, L. R.: Production of Psychology Doctorates, *Amer Psychol* 19:629-633, 1964.
9. VAN DE CASTLE, R. L., and EICHBORN, O. J., JR.: Length of Graduate Training for Experimental and Clinical Psychologists, *Amer Psychol* 16:178-180, 1961.
10. DICKEL, H. A.; DIXON, H. H.; and SHANKLIN, J. G.: Treatment of the Chronically Anxious Patient, *Family Physician* 14:12-19 (May) 1964.
11. DURANT, T. M.: *The Days of Our Years*, Philadelphia: Wyeth Laboratories, 1965.
12. THROCKMORTON, R.: An Outline of Some Important Principles of Medical Ethics, read before the House of Delegates, Oregon Medical Association, Portland, April 23, 1965.

A CRITICAL LOOK AT PROFESSIONAL EDUCATION IN THE MENTAL HEALTH FIELD

(Allen S. Mariner)

Various writers in the "mental health" field—that is, that area of human endeavor devoted to helping persons with emotional or psychological problems—have considered the problem of educational preparation for the field. Looming large in their considerations have been questions concerning the relevance of medical education and training to the actual practice of those working in the field. This questioning began almost as soon as the field was first defined in meaningful intellectual terms, and it was begun by the man who was most instrumental in defining the field as we know it today—Freud himself, in his well-known essay on "The Question of Lay Analysis" (1926) (5) (1). Since the appearance of this essay, others have added their arguments to Freud's original contribution; among contemporary writers, Kubie (1954,1957,1964) (12,13,14) (2,3,4), Szasz (1959,1961) (20,21) (5,6), Gardiner (1960,1962) (6,7) (7,8), Eissler (1965) (3) (9), and Schofield (1964) (17) (10), have addressed themselves to this problem.

Discussion of the issues involved has been severely hampered by intense inter-professional rivalries and by problems of definition. Among "medically-oriented" psychiatrists, the problem is "solved" by forcing the professionally observed and manipulated phenomena into what has seemed to many a Procrustean bed of quasi-medical terminology; by defining deviant behavior and feeling in terms of "illness" or "disease", these psychiatrists place such phenomena firmly within the domain of medicine. The defenders of this position have been vigorously challenged by militant clinical psychologists with the able backing of dissident psychiatrists. Psychiatric caseworkers and lay analysts have remained largely aloof from this argument, at least in print. Caseworkers have been beset with the most acute problems of professional identity: With rare exceptions, they lack the magic degree which enables one to be called "Doctor"; they frequently approach the issue with an air of diffidence and conciliation and become involved in apologetic and largely unsuccessful attempts to differentiate their practice of office "casework" from "psychotherapy" so that no one will be angry with them (Grinker, 1961; Hollis, 1964; Josselyn, 1948; Kaplan, 1963) (8,9,10,11) (11, 12, 13, 14). Lay analysts consider themselves strictly "psychoanalysts"; they stem directly from a European tradition and, because of the official position of the American Psychoanalytic Association, see themselves as a dying breed for whom there is no longer any point in fighting. They constitute a small group, but included among them are such illustrious and respected figures that they cannot be omitted.

I have thus introduced the four professional groups who supply most of the professional psychotherapeutic help given in this country at this time. (There are, of course, others who supply such help—some clergymen, nurses and even aides in certain psychiatric hospitals (Warne, 1965) (22) (15)—but the present discussion will be limited to the four more-officially-recognized groups.) Two questions immediately arise with reference to the work of these professionals:

1. To what extent can their work be identified with their professional origins?
2. Do the psychiatrists (including medical psychoanalysts) have a significant

Note: The references are indicated in the text in three different ways, corresponding to the three most common conventions for referencing. The system used by the *American Psychologist* (employing author names and dates) corresponds to the first parenthetical reference in each case. The second and third, employing numbering systems, may be ignored.—A. S. Mariner, M.D.

advantage over the others in the conduct of their day-to-day professional work? If they do have an advantage, from what does it stem? Is it specifically related to their medical training, and, if so, in what way?

To approach the first of these questions, let us imagine an experiment in which random samples of the work of experienced professionals from these four groups are observed by an experimenter who does not know the professional origins of the subjects. It will be immediately apparent that certain professional activities would identify the subject at once: if he were prescribing drugs or giving electroshock therapy, he would have to be a psychiatrist; if he were giving psychometric tests, he would almost undoubtedly be a psychologist; if he were using hypnosis, he would be either a psychiatrist or a psychologist; if he were making a home visit, he would in all likelihood be either a social worker or a psychiatrist; if he were engaged in an interview in which the patient was on a couch, he would be either a psychiatrist or a lay analyst. If, however, the experimenter were confronted with samples of professional behavior limited to "interview material" in the usual sense—individual, family, or group—he would find it extremely difficult, if not impossible, to deduce the subject's professional origins in terms of the so-called 'disciplines'. Instead, he would probably find himself identifying Freudian analysts, Jungians, Rogerians, "psychoanalytically-oriented" therapists, "rational-emotive" therapists, "existential-experimental" therapists, and other breeds. In other words, he would be able to make deductions about the theoretical bias of the therapist, about the teachers who had left their imprint on his work, and about the books he had read far more easily than he would about whether the subject had ever gone to medical school or held a doctorate in clinical psychology. While he might well be able to identify a psychoanalytic interview as such, he would undoubtedly not be able to tell whether the analyst had had medical training. Further, if he could observe the course of an entire therapy, he would still not be able to identify with any certainty the professional "discipline" of the therapist as long as the therapeutic contact included none of the "parametric" behaviors mentioned above and as long as the therapist's verbalizations did not include any jargon which is identified with one particular "discipline" (e.g., if a therapist spoke of "sharing information", he could probably be identified as a social worker on the basis of this verbal clue). It is assumed that the above assertions will not appear strange or untenable to most sophisticated workers in the psychotherapeutic professions. Those who wish corroboration are referred to the work of Hans Strupp (1960) (19) (16) and to the excellent discussion in Schofield's *Psychotherapy: The Purchase of Friendship* (Chapter 6) (1964) (17) (10). It has been found that even the observable differences among therapeutic schools tend to diminish with increasing age and experience of therapists.

It may be concluded, then, that the work of professionals in this field can be identified as to "discipline of origin" only when certain specific behaviors are employed; even then, there are very few such behaviors which could firmly identify a subject in our imagined experiment as having had medical training (assuming that he is not "wearing two hats" and functioning also as a general physician): performing physical examinations, prescribing or administering drugs, and giving electroshock treatment. (He might also be identified by certain administrative behaviors such as giving or withholding ward privileges in a hospital, signing commitment papers, or testifying in court as a legal sanity; these activities will be discussed later.)

With this fact in mind, we may proceed to the second of the two questions posed above: Do psychiatrists have a significant advantage over other therapists in the conduct of their day-to-day professional work? The preceding discussion makes it clear that this question must be subdivided into two questions:

(a) Do psychiatrists have a significant advantage when functioning purely as "psychotherapists" in the usual sense—that is, without employing physical methods?

(b) To what extent does the possibility of employing the physical methods mentioned above constitute an advantage for the psychiatrist?

Two main arguments have been advanced to sustain the claim that medical training confers an advantage on the psychotherapist; these might be termed the argument from knowledge and the argument from attitude and charisma. The proponents of the former maintain that the physician's knowledge of physical symptoms and disease constitutes an important part of the armamentarium of the psychotherapist and/or that this knowledge is essential because the therapist must assume what is termed "medical responsibility" for the patient.

The assertion that knowledge of physical medicine is important to the psychotherapist appears patently false when one considers the obvious fact that large numbers of non-medical therapists function quite effectively without this knowledge. Therapists of every background, medical and otherwise, routinely make a practice of depending on general physicians, internists, and other medical men for opinions and recommendations regarding organic problems in their patients; and the suspecting of organic disease is most assuredly not limited to psychiatrists. Two situations known to the author are relevant in this connection:

A psychologically sophisticated patient dismissed certain abdominal symptoms as being obviously "psychosomatic" because they appeared to be related to material with which she was dealing in therapy. Her therapist, however, insisted that she consult a physician. Examination revealed a twisted ovarian cyst. The therapist was a lay analyst.

A woman was seen in psychotherapy over a prolonged period because of persistent abdominal symptoms for which extensive physical investigations had revealed no cause. The therapist was convinced that the symptoms were somatic expressions of feelings related to the patient's intensely conflictual marriage; numerous connections between various symptomatic manifestations and the vicissitudes of the marital situation were observed in the course of the therapy. The treatment ended precipitously when the patient consulted a surgeon whom she had never seen before; this surgeon performed a laparotomy and found the patient's peritoneal cavity to be extensively invaded by a malignant tumor. The therapist in this case: a psychiatrist.

Further examples may be found in Eissler's *Medical Orthodoxy and the Future of Psychoanalysis* (1965) (3) (9).

The term "medical responsibility" is often used but seldom defined. Operationally, one assumes responsibility when one agrees to perform a certain function (professional or otherwise). What, exactly, does one who assumes "medical responsibility" take upon himself? The answer, obviously, is that the responsibility varies according to the field in which the professional is working. The ophthalmologist assumes responsibility for diagnosing and treating eye conditions; he does not assume either diagnostic or therapeutic responsibility for other conditions. If a patient mistakenly visits his office with intestinal complaints, he does not assume any responsibility for the patient other than to refer him to an appropriate source of help. If he has a patient in the hospital for an eye operation, he asks a general physician to do the routine physical examination. If the patient develops post-operative pneumonia, he will assume the responsibility for calling in an internist to treat the pneumonia; he will not take the responsibility for diagnosing and treating it himself because he (quite correctly) considers it outside his realm of competence. Thus even within the field of organic medicine, "medical responsibility" is not a global responsibility; institutional rhetoric and operational reality are two different things.

In the psychiatric field, the confusion is particularly important because an issue is made of the "medical responsibility" concept. The ophthalmologist is not criticized because he does not assume the responsibilities of the general physician or the internist, but the psychiatrist is admonished—albeit with no clarity of thought—to "assume medical responsibility for the patient". This injunction may be viewed from both sides—the psychiatrist's and the patient's. From the psychiatrist's side, one immediately sees a strange contradiction: the psychiatrist is told to assume medical responsibility but is also repeatedly—and correctly—reminded that he cannot or should not assume it, both because he no longer has the competence and because of the difficulties involved in trying to play both medical and psychotherapeutic roles (Kubie, 1954; Colby, 1951) (12.2) (2, 17). From the patient's side, as Szasz (1959) (20) (5) has pointed out, it would appear quite unwarranted to transfer responsibility for physical health matters from the patient and his physician to the psychiatrist.

The assertion that the psychiatrist should assume medical responsibility is frequently coupled with the idea, usually expressed covertly, that physical disease is an ever-present possibility in the psychotherapy patient. Kubie, for example, in his long and valuable paper on "The Pros and Cons of a New Profession: A Doctorate in Medical Psychology" (1954) (12) (2), advises that patients in psychotherapy be subjected periodically to "meticulous organic scrutiny" lest some physical abnormality be overlooked. There would appear to be only two possible rational reasons for such physical investigation of the patient who is undergoing psychotherapy for, let us say, exhibitionism or agoraphobia: (a) the exhibitionism or agoraphobia (and I must stress that these are randomly chosen

examples) is suspected of being basically organic in origin—a most unlikely suspicion; or (b) exhibitionists and agoraphobics are more prone to physical disease than other people and should therefore have regular physical examinations more frequently. There is a striking paradox inherent in this position—namely, that if a patient deemed it necessary to subject himself to repeated physical examinations in the absence of any signs or symptoms of physical diseases, his behavior would almost undoubtedly be adjudged indicative of hypochondriacal anxiety or unwillingness to give up the defensive idea that “it’s really physical”. Thus, it is as if the very behavior which would be deemed neurotic on the part of the patient were to be institutionalized as desirable or even essential on the part of the therapist. Actual practice, of course, is more realistic: psychotherapy patients are not subjected to periodic physical examination, whether their therapists are medical or non-medical; like everyone else, they consult medical men when some indication for such consultation arises. There is no rational basis for the assumption that a person involved in psychotherapy is, for that reason alone, any more apt to develop organic diseases than anyone else.

(Kubie in the above-mentioned paper introduces another—and even stranger—“argument from knowledge” when he suggests that only physicians can recognize psychosis. The reaction of any seasoned clinical psychologist to this suggestion need not be described.)

A widespread misunderstanding exists with regard to the medically-trained therapist—namely, that his behavior *as a therapist* reflects his medical knowledge. Operationally, this is simply not true. Unless he is functioning also as a general physician, the psychiatrist-therapist does not actually *do* anything about physical symptoms or physical illness in his patients which is *in any way* different from what the non-medical therapist does. He deals with these phenomena as aspects of the patient’s psychological world; he may be concerned about their meaning to the patient or about the patient’s ways of dealing with them, but he will not undertake to deal with them himself at the physical level. Thus, a therapist may focus a patient’s attention on his reluctance to seek medical help for suspected or obvious physical diseases but he will not attempt to diagnose or treat the physical disease himself. These statements are just as true in cases involving the so-called “psychosomatic” diseases as they are in such cases as that of the patient who breaks his leg in a skiing accident in the course of psychotherapy. The psychiatrist does not prescribe a diet for—or perform a gastric resection on—the patient with a peptic ulcer, nor does he set the fracture of his skiing patient.

In summary, *the mental health professional assumes responsibility for the mental health task*; the extent to which this task is “medical”—and hence requires a medical education—is the basic question to which this paper is addressed.

To pursue this question at a very practical level, I decided to list all the courses of my own pre-medical and medical education for the purpose of assessing their relevance to my own functioning as a psychotherapist. I knew that I would find more in the “irrelevant” column than in the “relevant” column, but I was somewhat surprised at the enormous imbalance. Being as realistic and honest as possible, I had to conclude that virtually all of my internship and medical school experience, with the single exception of the specifically psychiatric courses and clerkships, was irrelevant. The required pre-medical courses in biology, chemistry, physics, and mathematics were also, of course, grossly irrelevant. Courses in English composition and literature fared somewhat better, the former as training in the organization and presentation of thought and the latter as an exposure to some of the vagaries of human behavior. Two elective college courses in philosophy and ethics seemed to have more direct relevance to the kinds of problems with which I deal than did all the endless hours of chemistry, zoology, pathology, surgery, and the like. (I do not, of course, mean to imply that all of these “irrelevant” courses were totally worthless in terms of general educational background; I am concerned here only with the question of more or less direct relevance to a particular professional task.)

What, then, did prepare me to be a psychotherapist? Very simply, residency training *in therapy*, reading, and experience (including experience as a patient, both in analysis and in analytically-oriented psychotherapy). For none of these was my medical background necessary or even significantly helpful.

The accompanying diagram is an attempt to present the interrelationships among the various elements in my professional background (Fig. 1).

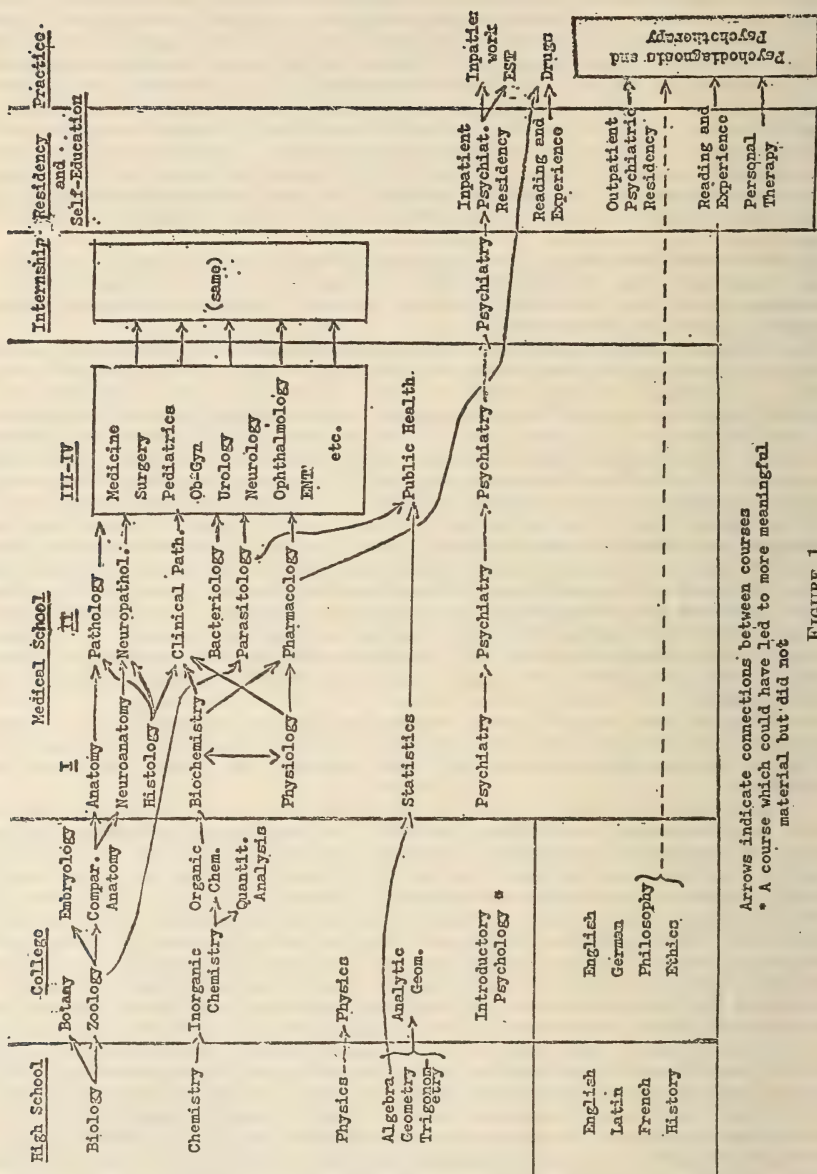


FIGURE 1

The other argument in favor of medical training for the psychotherapist is the argument from attitude and charisma. It is sometimes held that "only the doctor" (i.e., the physician) can assume the proper therapeutic attitude toward the patient and command the supposedly necessary degree of reverence from him (Zilboorg, 1943) (24) (18). The patently institutional assertion that physicians have a monopoly on therapeutic attitudes is one which seems too manifestly false to warrant detailed refutation. Anyone who has open-mindedly worked with physicians and with non-medical psychotherapists knows that attitudes toward patients and modes of relating to them vary with the personalities and theoretical orientations of the professionals and cannot be related to academic background in any direct way. Further, it has been repeatedly and clearly pointed out that the nature of the relationship between psychotherapist and patient is distinctly different from that between physician and patient (Sobel, 1964; Wheelis, 1958) (18,23) (19, 20). Specifically, it is worth noting that physicians habitually speak of "taking care of" their patients, the psychotherapist is frequently actively concerned with getting the patient to "take care of" himself and speaks of "seeing" or "working with" a patient. Thus one might well question the desirability of a traditional 'medical attitude' in dealing with the psychotherapy patient.

One particularly subtle way in which psychiatric writers sometimes imply that non-medical therapists are "inferior" is exemplified by the familiar statement that the threat of suicide represents a *medical* emergency; one writer (Lesse, 1965) (15) (21) has compared it directly with threatened coronary occlusion. The hidden implication in this statement is that conditions or situations which are "serious" are *ipso facto* "medical" and that only physicians "can" or "should" deal with them. That the threat of suicide is a serious problem very few would deny, but conditions which are serious are not necessarily "medical"; the threat of suicide might more appropriately be termed a "humanistic emergency", a "psychological emergency", perhaps even an "existential emergency". There is no logical reason for placing a problem in the domain of medicine simply because of its "importance" or "seriousness"; the substantive content of the problem should be the determining factor. Similarly, there is no reason to assume that the ability to behave in a "responsible" manner, both in a general human sense and within the framework of a professional role, is inextricably linked with medical experience.

It may be granted that for some patients the charisma of the physician is an important determinant of attitudes and behavior (Frank, 1961) (4) (22). For reasons of status, because of misinformation regarding professional functioning, or for manipulative reasons, certain patients insist on having medical therapists. This sort of behavior on the part of a patient, however, is clearly irrational; and for psychiatrists to capitalize on it as a justification for asserting a therapeutic monopoly is strangely ironic. They frequently do, however; and non-medical therapists often fall into the trap, defining themselves into a state of "inferiority"—and hence of lessened therapeutic efficacy—as a result of exposure to the medical "party line".

It seems clear, then, that whatever advantage accrues to the psychiatrist functioning as a psychotherapist stems not from his medical knowledge but from irrational attitudes on the part of his patients, his colleagues, and himself (or, of course, from non-medical training experiences).

We may now ask whether the availability of physical techniques as adjuncts or alternatives to purely psychotherapeutic methods constitutes a significant advantage for the psychiatrist in contrast to other therapists. There are, as noted above, three such techniques to be considered, one diagnostic and two therapeutic. The diagnostic technique is, of course, the physical examination. The most obvious fact relevant to this technique is that the psyche—the object of study of *psychiatry* and *psychology*—is not a physical object and hence cannot be examined physically; its disorders cannot be diagnosed by physical methods. It is hardly surprising, therefore, that most psychiatrists do not perform physical examinations except on hospitalized patients, and then frequently only as a matter of routine compliance with hospital rules. I am sure that I am by no means atypical in reporting that I have not done a single physical examination in eight years of private office practice and three years of clinic practice. I am sure also that I am not atypical in stating that I would not trust my own ability as a physical diagnostician in any but the most obvious situations. In the kinds of cases in which the interpretation of physical findings is diagnostically im-

portant—cases involving cardiac symptoms, suspected hyperthyroidism, questionable neurological manifestations, and the like—sound practice demands the sort of reliable and expert opinion which can be provided by the internist or the neurologist, not the opinion of one whose expertise lies in quite a different field. For really serious purposes, then, the physical examination is not a functioning part of the average psychiatrist's armamentarium. To maintain sufficient expertise in physical diagnostic observation to offer definitive judgments in cases such as those mentioned above, the psychiatrist would have to continue to perform numerous physical examinations; such use of psychiatric time would appear manifestly unwarranted in view of the availability of specialists in the appropriate medical fields.

It is a fascinating irony that many psychiatrists who hold the view that physical medicine is an appropriate basis for mental health practice and who would object strenuously to any questioning of the relevance of physical examination techniques to that practice make no secret of their ignorance of the only *psychodiagnostic* tools we have other than the interview (or pure observation)—i.e., psychological tests. Whatever may be their usefulness, they constitute the only method we have which even roughly approaches the diagnostic tests of physical medicine; it would seem only reasonable, therefore, for all workers in the field to be at least somewhat conversant with them.

The prescribing of drugs has become a far more important part of psychiatric practice since the advent of the "psychotropic" drugs; and while there are some psychiatrists who avoid all use of drugs, there can be no doubt that for many, the ataractics, antidepressants, sedatives and stimulants comprise a useful set of pharmacological tools (Bahn et al., 1965) (1) (23). Even those psychiatrists who use these drugs infrequently would presumably agree that they do contribute significantly in the task of helping certain emotionally disturbed people, particularly the psychotic and the severely depressed.

The actual administering of drugs by psychiatrists is usually limited to hospital situations. There are a few psychiatrists who occasionally use intravenous pentothal for office interviews, but this practice is apparently extremely rare, and most psychiatrists' offices are not equipped for this sort of medical procedure—a fact which in itself indicates that most psychiatrists do not regard it as a significantly helpful technique. It is safe to say that the overwhelming majority of drugs employed by psychiatrists are prescribed, not directly administered by the psychiatrist himself.

The use of electroshock has, of course, decreased markedly since the beginning of the "drug era". There remains, however, a group of patients for whom it is unquestionably extremely useful, if not irreplaceable; these are the patients with severe endogenous depressions who do not respond to antidepressant drugs and with whom psychotherapy is a practical impossibility. It is of crucial importance to note, however, that many, if not most, psychiatrists do not actually give electroshock therapy themselves. It is, for this large group, a specialized procedure for which they refer patients to practitioners who employ it frequently and who are thoroughly familiar with its use and with the complications which may ensue. These practitioners are equipped, either in hospitals or—less often—in their offices, with the apparatus and additional staff needed to administer the treatment; they are also covered with the substantially larger amounts of insurance required. Since the number of patients for whom electroshock is definitely "indicated" has shrunk so drastically with the advent of the psychotropic drugs, this specialization appears inevitable and appropriate. The relevant conclusion in terms of the larger question being considered here is that *awareness of indications* for electroshock and its *availability* are important for most psychiatrists while the actual giving of the treatment is frequently left to those who make a specialty of it.

Of the three distinctly medical techniques under discussion, then, only one—the prescribing of drugs—is commonly employed by large numbers of psychiatrists. It is important to note that the list of drugs used by psychiatrists is a very short one in comparison to the entire pharmacopoeia, being limited, with most practitioners, to tranquilizers, antidepressants, sedatives, and energizers. The implications of this observation will be developed further later in the discussion; a question may be posed at once, however, as to whether it may be realistically claimed that four years of medical education is an operationally necessary prerequisite for the prescribing of four very limited classes of drugs.

There are, as noted earlier, certain administrative behaviors which are almost invariably performed by psychiatrists and hence could serve to identify the

subject in our imagined experiment; such behaviors would include hospitalizing patients, giving and withholding privileges on psychiatric wards in hospitals, signing commitment papers, testifying as to legal sanity, and the like. When the suggestion is made that such activities could just as effectively be carried out by—for example—clinical psychologists, the outrage of the psychiatrist frequently finds expression in some such question as: "Would you want anyone but a doctor to make decisions like these?" It is asserted that only the physician can "take the responsibility". This sort of assertion indicates not only "status panic" but also a complete confusion of operational and institutional considerations. When the psychologist states that he "cannot"—for example—sign commitment papers, he is saying simply that institutional regulations do *not* permit him to sign them; he is *not* saying that he lacks the knowledge or judgment to do so. If one is careful to avoid the institutional trap, it appears obvious that medical training is not in any way operationally necessary for the performance of the administrative behaviors being considered here. What *is* necessary is the observational skill and judgment which comes only from experience with disturbed people—experience which is common to psychiatrists and other mental health professionals but not, frequently, to general physicians, who, because of the institutional rules, "can" make various administrative decisions about people who come under their scrutiny (e.g., sign commitment papers).

One type of professional behavior which is sometimes mentioned as inherently "medical" is the applying of diagnostic labels. Here again one encounters confusion between institutional rules and operational realities. As an example, in Florence Hollis's recent book entitled *Casework: A Psychosocial Therapy* (1964) (9) (12)—which is, as one reviewer pointed out, a treatise on psychotherapy as practiced by caseworkers—the author makes this statement (p. 195): "An opinion about the nature of a mental disturbance becomes a medical diagnosis only when it is expressed by a physician." If a social worker labels a client "schizophrenic", this is "a casework diagnosis . . . designed for casework treatment". Presumably, then, a similar diagnosis made by a psychologist would be a "psychological diagnosis"—something different from a "casework diagnosis" and different also from a "psychiatric diagnosis". In reality, all three professionals are saying the same thing, performing the same professional act, when they state that a patient (or "client") is "schizophrenic", providing only that they agree on the meaning of the term. If disagreements arise among professionals of different "disciplines" about matters of diagnosis, they are true disagreements, not artifacts resulting from differences in professional origin.

I have defined the "mental health" field as "that area of human endeavor devoted to helping persons with emotional or psychological problems"; it is, to be somewhat more expansive, the field of man's anxieties, depressions, irrational doubts and fears, irresponsibilities, disturbed social relations, maladaptive behavior, disturbed thinking—the field of the *psychic* problems of man *as man*, a social, symbolizing being, not man as a biological machine. It is altogether appropriate to ask, from an operational viewpoint unhampered by any pre-existing institutional rules, what we need to know about man in order to help him with these kinds of problems (and—if need be—to make decisions about him when he becomes socially incompetent in the course of trying to deal with them).

This sort of question may be approached from a theoretical base or from the practical, purely operational surface, with subsequent inquiry into the relevant underpinnings of operational knowledge. From a theoretical point of view, to an observer unhampered by institutional concerns, it would seem apparent that a knowledge of human behavior, thought, and emotion would be the logical and necessary foundation on which a professional practice dealing with disturbance of behavior, thought, and emotion would have to rest. Thus psychology—or, more generally, "behavioral science"—would seem, unquestionably, to be the basic academic discipline of choice. (That this should be considered a heretical statement when made by a psychiatrist is evidence of the almost incredible irrationality of the medical profession in this area; "a psychological background for dealing with psychological problems" would seem as obvious a choice as "a biological background for dealing with biological problems".) The relevance of personality theory, learning theory, communication theory, and the study of group interactions seems too obvious to need emphasis. Also relevant to the professional task would be some knowledge of sociology, to provide a broader perspective and to place the individual and the family in a social frame-

work, and some knowledge of human biology, of the body in and through which man perceives his environment and expresses himself. A broad humanistic education and education in scientific method should be included to guard against what the French so aptly term *déformation professionnelle*.

To approach the question from the other direction, the earlier discussion of the operational surface of the mental health professions may here be briefly recapitulated: The work of the mental health professional consists mainly of formulating, within some psychological theoretical framework and in psychological (or socio-psychological) terms, the problems presented to him by those who seek (or are brought into) his professional influence, and attempting to ameliorate these problems. The methods used in the formulating (or "diagnostic") aspect of the professional task are interviews of various sorts and, sometimes, psychological testing. The methods used in the therapeutic aspect of the task are—again—interviews of various sorts (individual, family, group, etc.), environmental structuring (e.g., hospitalization), the prescribing of a limited number of "psychoactive" drugs, and (in a decreasing number of cases) electroshock therapy or referral for such therapy.

What are we to make of the fact—and I take it to be a fact—that good "diagnosticians" and good therapists come from backgrounds which include nothing in common beyond training and experience in formulating and working with human problems by means of interviews? What are we to make of the discomfiting fact that Janet Rioch can train intelligent housewives to perform quite competently as therapists without the benefit of specific backgrounds in any of the usual "disciplines" (Pines, 1962) (16) (24)? What of the fact that psychiatrists with no training whatever in psychology other than psychoanalytic theory can be excellent therapists? The clear implication of these facts is that psychotherapy is still largely without true scientific underpinnings—is still, to use a cliché, as much art as science (perhaps, alas, more art than science).

Just as surely as this is the case today, however, the academic field to which we must look for elucidation of what we are already doing in diagnostic and therapeutic interviewing—and for *scientific* instruction in how we might do it better—is psychology—whether it be the study of the intrapersonal psyche, the study of interpersonal behavior, or the study of the effects of hospital ward environments. If the practice in which we spend most of our time—namely, the psychological aspect of mental health work—has any scientific validity whatever, then our common basis discipline is psychology. If the important "answers" are really to be found in some other area—for example, neurophysiology or biochemistry—then we have been wrong all along—just as wrong as one would be in trying to treat a uremic delirium by psychotherapy. If, for example, certain cases of what we call "schizophrenia" were found to be caused by a chemical deficiency, those cases would at that point pass out of the realm of the mental health professional and into the realm of organic medicine (like delirium tremens, general paresis, and psychoses associated with brain tumors). The particular manifestations and emotional reverberations of the chemical aberration might be investigated psychologically, but the basic problem would be a medical one.

It may be objected that although the disturbances with which we deal are "psychological", physical methods can be—and are being—found to take the place of that cumbersome and time-consuming activity known as psychotherapy. In this view, pragmatic therapeutic "answers" may come from such fields as biochemistry and neurophysiology even if the theory explaining the disturbances remains psychological. To the extent to which this view proves valid, the mental health field as an area of psychological therapeutic effort will cease to exist. If it were learned, for example, that anxiety could be effectively and easily dealt with by inserting a needle into a specific area of the thalamus, then the relevant training would be that of the neurosurgeon. (We may leave aside the Orwellian questions raised by such an idea.) This sort of therapeutic activity could be labeled "psychiatry" only by a change in the meaning of the term. It is conceivable that a new *medical* specialty may evolve, based on neurosurgical, neurochemical, and neurophysiological methods; such a specialty, however, would be far removed from what we know today as "psychiatry", and the specialty training which today's psychiatrists receive would be almost as irrelevant to its practice as medical education is to most of the activities of today's psychiatrists.

Among the pragmatic physical therapeutic modalities now in use, the "psychoactive" drugs, as indicated earlier, are by far the most widely used. For the

practicing psychiatrist, the use of these drugs is an empirical activity based on knowledge of their psychic effects and not on knowledge of their chemistry or their lool of operation within the nervous system. Put in bald, practical terms, this means that the psychiatrist knows that four milligrams of a chemical known as Stelazine, for example, may—if taken two or three times a day—modify psychotic behavior in certain presumably desirable ways. He does not know—nor does he need to know—the chemistry of this drug; he does need to know what may happen if too much of it is ingested, what side-effects it may produce, and that people with damaged livers should not take it.

I would venture to say—again heretically—that all the factual material relevant for the effective and practical use of the psychoactive drugs could be learned in two weeks by the average intelligent student in the mental health field. Anyone who is inclined to dismiss this statement as absurd might well reflect on the fact that many practicing psychiatrists went through their entire training before the tranquilizers and the antidepressants had even been heard of. These psychiatrists spent their weeks and months in pharmacology courses learning facts about drugs which, except for the sedatives and a small number of amphetamine preparations, they have never used and never will use in their work as psychiatrists. Thus, their knowledge of—and experience with—the newer drugs stems entirely from their own informal self-educative activities, while their formal training in pharmacology was largely devoted to material having no relevance to their later practice. It is not implied here that formal training in pharmacology is unnecessary (“psychopharmacology” would be far more to the point than months spent in learning the intricacies of various digitalis preparations, antibiotics, and dozens of other drugs which are of vital importance to the work of the physician dealing with physical illnesses but of no importance to the work of the mental health specialist. Operationally, one certainly does not have to be able to prescribe *all* drugs in order to prescribe *some* drugs; institutional rules have already encompassed this fact in regulating the prescribing done by podiatrists, for example.

The important questions confronting any professional field serve as good indicators of the underpinnings of knowledge relevant to the field. In the mental health field, there are such questions as these:

Is anxiety generated and maintained in a purely reflex fashion (as the behavior therapist would say), as a result of cognitive processes (as the rational-emotive therapist would say), or as a result of conflict between instinctual drives and intrapsychic repressive forces (as the psychoanalyst would say), or by different mechanisms in different situations?

To what extent is behavior unalterably determined by infantile and early childhood experiences? How “free,” in the existential sense, is man?

How much of what we observe in human behavior is attributable to intrapsychic forces and how much to interpersonal influences? What is the interrelationship between the intrapsychic and the interpersonal?

What really happens in the various forms of psychotherapy?

What is the role of values in the practice of psychotherapy?

The questions raised by the co-existence of such diverse practitioners as existential-experimental therapists on the one hand and behavior therapists on the other lead swiftly to questions about the very nature of man. Significantly, however, these—like the questions listed above—are all questions for the psychologist or the philosopher, not for the anatomist or the physiologist. Even the most reductionistic of the therapeutic approaches, behavior therapy, comes straight from the laboratory of the experimental psychologist. Of the really important questions confronting the mental health field today, only three are not basically questions in psychology, sociology, or ethics:

1. Are there biochemical and/or genetic abnormalities which play a causative role in schizophrenia?

2. Are endogenous depressions really manifestations of physiological malfunction?

3. To what extent does “subclinical” cerebral dysfunction play a part in childhood behavior disorders?

The investigation of these questions is properly in the hands of the biochemists, the geneticists, and other researchers; it is beyond the professional scope of the psychiatrist as we usually know him, despite his medical training. And, to repeat, if these conditions should be found to be, let us say, “metabolic diseases”, they would cease to be primarily “mental health problems” in the same way

that "psychosomatic headaches" cease to be a "mental health problem" when they are discovered to be caused by a brain tumor.

The mental health professional, then, is really working in the field of applied psychology in the best sense of that much-misused term—psychology applied to the task of alleviating psychological suffering—with some excursions into the realm of applied psychopharmacology. This is his true operational field no matter what his professional background has been. That jurisdiction over this field should be claimed by a profession whose basic education usually includes not a single course in psychology is, when viewed dispassionately, little short of fantastic.

My purpose in this paper is not to propose the details of a curriculum for future mental health professionals, but rather to evaluate the present education of the most influential of these professionals—the psychiatrists—and to suggest a direction for change. Such change must be in a psychological direction if our education is to make sense in terms of the realities of our professional work. When is some enterprising university going to formulate a curriculum for a School of Mental Health, based on the existing curriculum in clinical psychology and including appropriate additions from other fields (medicine, sociology, social work), and produce graduates whose work can then be compared with that of their more traditionally trained colleagues? It is a dream worth considering.

REFERENCES

- Bahn, A. K., Conwell, M., and Hurley, P.: Survey of Private Psychiatric Practice. *Arch. Gen. Psychiat.*, 1965, 12:295-302
- Colby, K. M.: *A Primer for Psychotherapists*. New York, Ronald Press, 1951
- Eissler, K. R.: *Medical Orthodoxy and the Future of Psychoanalysis*. New York, International Universities Press, 1965
- Frank, J. D.: *Persuasion and Healing*. Baltimore, Johns Hopkins Press, 1961
- Freud, S.: *The Question of Lay Analysis*. (1926) London, Imago Publishing Company, 1947 (First English Edition)
- Gardiner, M.: A Note on Accreditation. *Bull. Phila. Assoc. for Psychoanal.*, 1960, 10:56-58
- Gardiner, M.: The Seven Years of Dearth. *Bull. Phila. Assoc. for Psychoanal.*, 1962, 12: 168-170
- Grinker, R. R., Sr., et al: *Psychiatric Social Work: A Transactional Case Book*. New York, Basic Books, 1961
- Hollis, F.: *Casework: A Psychosocial Therapy*. New York, Random House, 1964
- Josselyn, I. M.: The Caseworker as Therapist. *J. Soc. Casewk.*, 1948, 29: 351-355
- Kaplan, A. H.: Social Work Therapy and Psychiatric Psychotherapy. *Arch. Gen. Psychiat.*, 1963, 9:497-503
- Kubie, L. S.: The Pros and Cons of a New Profession: A Doctorate in Medical Psychology. *Tex. Reports on Biol. and Med.*, 1954, 12:692-737.
- Kubie, L. S.: Need for a New Subdiscipline in the Medical Profession. *Arch. Neur. and Psychiat.*, 1957, 78: 283-293
- Kubie, L. S.: A School of Psychological Medicine within the Framework of a Medical School and University. *J. Med. Educ.*, 1964, 39:476-480
- Lesse, S.: The Psychotherapist and Apparent Remission in Depressed Suicidal Patients. *Am. J. Psychother.*, 1965, 19:436-444
- Pines, M.: Training Housewives as Psychotherapists. *Harper's Magazine*, 1962, 224:37-42.
- Schofield, W.: *Psychotherapy: The Purchase of Friendship*. Englewood Cliffs, Prentice-Hill, 1964
- Sobel, R.: Role Conflict or Resistance. *Am. J. Psychother.*, 1964 18:25-34
- Strupp, H. H.: *Psychotherapists in Action*. New York, Grune and Stratton, 1960
- Szasz, T. S.: Psychiatry, Psychotherapy, and Psychology. *Arch. Gen. Psychiat.*, 1959, 1:455-463
- Szasz, T. S.: *The Myth of Mental Illness*. New York, Hoeber-Harper, 1961
- Warne, G. E.: Consulting with Aide-Therapists. *Arch. Gen. Psychiat.*, 1965, 13: 432-438
- Wheelis, A.: *The Quest for Identity*. New York, W. W. Norton, 1958
- Zilboorg, G.: *Mind, Medicine, Man*. New York, Harcourt, Brace, 1943

Dr. BRAYFIELD. Thank you, sir. The medicare law insures the patient for services afforded for the diagnosis and treatment of mental, psychoneurotic, or personality disorders. Under title XVIII, part

A, such services rendered by a psychologist to inpatients in psychiatric facilities are, according to the regulations, covered as inpatient hospital services.

PSYCHOLOGIST'S SERVICES MADE "INCIDENT TO A PHYSICIAN'S SERVICES"

Our present concern is with title XVIII, part B. Recently promulgated regulations indicate that the services of a psychologist are not covered unless they are "incident to a physician's services." Specifically, the regulation states:

Services provided by psychologists in physician-directed mental health clinics, and services provided in the office of a physician in private practice by a psychologist employed by the physician, if charges for the psychologist's services are commonly included in the physician's or clinic's bills, are covered under Part B as incident to a physician's services.

REQUIREMENT IS CONTRARY TO PUBLIC INTEREST

We submit that the public interest is not served by this restriction on direct access of patients to services offered by a psychologist. Qualified psychologists are unlikely to be employed in the offices of private physicians in any significant number, and the clinics in which they serve may not be directed by a physician.

Thus the presently limited supply of manpower is curtailed by this apparently necessary construction of the law.

Also, diagnostic psychological testing is covered when performed by a qualified psychologist only upon physician referral.

In both instances, the unnecessary intermediary step of physician referral is an added cost to the Government. Psychology is an independent and autonomously practicing profession and is so recognized presently by statute in 30 States and in numerous court decisions. The requirement that the psychologist's services be "incident to a physician's services" unnecessarily increases the cost of the program, restricts the available supply of manpower and, importantly, tends to restrict the patient's freedom of choice among essentially comparable services.

Ironically, although part B of the act imposes a limit upon the reimbursable expenses incurred by an individual for outpatient treatment of mental, psychoneurotic, and personality disorders when the service is provided by a physician, there is no ceiling placed upon the expenses when the service is provided by a psychologist "incident to a physician's services." It is difficult to justify this discrimination against a physician or psychiatrist.

REQUIREMENT CONTRADICTS EARLIER CONGRESSIONAL INTEREST

I should like now to call your attention to the fact that the medicare legislation, in the manner noted above, appears to contradict a basic principle regarding the provision of mental health services enunciated in other contexts by the Congress.

Thus, in 1961, the Joint Commission on Mental Illness and Health, a creature of the Congress, after intensive study of the "questions of authority, professional prerogatives, and qualifications involved in

the treatment of the mentally ill," concluded that the "only principle that can satisfy all interested parties, including the public, is one of individual competence to undertake a given approach to a patient."

This principle was reaffirmed in Senate Report No. 366, 89th Congress, first session, subsequent to its consideration of H.R. 2985, and S. 513 the "Initial Staffing for Community Mental Health Centers" bills as follows:

There is no intent in any way in this bill to discriminate against any mental health professional group from carrying out its full potential within the realm of its recognized competence. Even further it is hoped that new and innovative tasks and roles will evolve from the broadly based concept of the community mental health services.

Specifically, overall leadership of a community mental health center program may be carried out by any one of the major mental health professions. Many professions have vital roles to play in the prevention, treatment, and rehabilitation of patients with mental illnesses.

The same principle was stated in the House of Representatives by Oren Harris, floor manager for the bill.

Also, the U.S. Public Health Service advisory bulletin titled "Improving Mental Health Insurance Coverage" (NIMH, 1965) states:

Both the continuing development of the mental health treatment team and the present shortage of mental health personnel argue strongly for covering the service of all mental health disciplines, including the clinical psychologist, the psychiatric social worker, and the psychiatric nurse.

That bulletin does not recommend or suggest that medical referral be required.

In view of these recent trends and policies in mental health legislation and programs at the Federal level, we view with deep concern the fact that the administration package for Social Security Amendments for 1967 submitted only recently by your committee chairman as H.R. 5710 takes no steps to rectify these inequities in the medicare legislation.

In lieu of extending my discussion along these lines, I should like now respectfully to request that this pamphlet, the American Psychological Association's formal position statement titled the "Psychologist and Voluntary Health Insurance," be received at this time and made a part of the hearings record.

Mr. WATTS. We are delighted to have it. Without objection, it will be included in the record.

(The material referred to follows:)

THE PSYCHOLOGIST AND VOLUNTARY HEALTH INSURANCE

(Published by the American Psychological Association, Inc., 1200 Seventeenth Street, N.W., Washington, D.C. 20036, May 1966)

FOREWORD

As the insurance industry has enlarged its experience with insurance protection for mental and emotional disorders, it has become increasingly aware of the extent to which professional diagnostic and treatment services are provided by psychologists in independent practice, community clinics, and hospital settings.

At the same time, individuals and consumer groups have demonstrated their increased interest both in such insurance coverage and the availability of qualified professional personnel to render services under such plans.

Psychologists, in turn, have recognized the important role of voluntary, pre-paid insurance in the provision of mental health care.

Exploratory discussion with insurance carriers and consumers over the past several years have led representatives of the American Psychological Association to make more generally available materials which describe the interest and role

of psychologists, particularly clinical psychologists, in mental health services and in the provision of health insurance protection. This booklet has been prepared for this informational purpose. It is the product of the APA ad hoc Committee on Insurance and Related Social Developments and is distributed with the approval of the Board of Directors, American Psychological Association.

ACKNOWLEDGMENTS

The following APA members contributed to the preparation of this booklet.

Ad hoc Committee on Insurance and Related Social Developments: MILTON THEAMAN, PhD, Chairman; members GEORGE E. COPPLE, PhD; NICHOLAS A. CUMMINGS, PhD; MELVIN A. GRAVITZ; PhD; WILLIAM F. SMITH, PhD; ROGERS H. WRIGHT, PhD.

Also JOSEPH B. MARGOLIN, PhD, and ALLEN V. WILLIAMS, MA.

Also APA Central Office staff members: JOHN J. McMILLAN, PhD, Administrative Officer, State and Professional Affairs, and ARTHUR H. BRAYFIELD, PhD, Executive Officer.

WHAT IS PSYCHOLOGY?

Psychology is both a science and a profession. Psychologists engage in research concerning mental and emotional processes, both normal and abnormal, and apply such knowledge to the enhancement of the health, effectiveness, and productivity of the individual person.

Historically, psychology provided the core of behavioral science knowledge through research and teaching in the university. More recently, in response to public interest and demand, psychology has applied its findings in such areas as industrial psychology, military psychology, vocational rehabilitation, school and counseling psychology, and psychological assessment and psychotherapy. Through research and practice in schools, industry, the armed forces, the Veterans Administration and other government agencies, public and private hospitals, community and private agencies, and in private practice, psychologists have contributed significantly to advances in the diagnosis and treatment of mental and emotional disorders.

The combination of scientist and professional, which the psychologist represents, fosters prompt and effective utilization of research findings in meeting the mental health needs of the nation.

WHO SPEAKS FOR PSYCHOLOGY?

Nationally, psychology is represented by the American Psychological Association (APA) founded in 1892. The APA has more than 24,000 members and includes 85-90% of all psychologists eligible for membership. Many of its activities are organized around its divisions, presently 24 in number, which represent areas of specialized interest in psychology.

General qualifications for voting membership in the Association include a doctoral degree based in part upon a psychological dissertation and conferred by a graduate school of recognized standing. Standards for divisional membership may impose additional qualification requirements for membership. *Fellow* status may be conferred upon members for whom divisions present evidence of unusual and outstanding contribution or performance in psychology.

Affiliated with the APA are state associations in all but one (Alaska) of the 50 states and associations in the District of Columbia, Puerto Rico, and the Province of Ontario, Canada. These associations represent psychology in their geographical area as affiliates of the APA.

As the national organization of psychologists, the American Psychological Association maintains close liaison relationships with the White House, the Congress, government agencies such as the National Institutes of Health, the National Science Foundation, the Social Security Administration, and the U.S. Civil Service Commission, with the other mental health professions, and with citizens' organizations such as the National Association of Mental Health. The Association represents American psychology in the World Federation of Mental Health.

The Association frequently is requested by congressional committees to offer expert testimony in a variety of fields including mental health. The Association also is called upon by the executive branch of government to provide consultative or advisory representation. For example, an APA representative is on the Advisory Council of the Department of Psychiatry, Neurology, and Psychology of the Veterans Administration. The Association is also represented on a num-

ber of national commissions concerned with health, education, and welfare problems of the public.

An important function of the Association is the exchange of scientific and professional information; it publishes 13 journals covering a range of fields of psychology. The *Journal of Abnormal Psychology*, the *Journal of Consulting Psychology*, the *Journal of Personality and Social Psychology*, and the *Journal of Applied Psychology* are directly relevant to the mental health field. *Psychological Abstracts* covers the world scientific literature in psychology and related fields.

The state associations represent psychology in the states. They are consulted by state officials and agencies on matters affecting the public welfare, they nominate psychologists for state psychology boards and for state advisory committees and commissions, they maintain communication with local professional organizations and citizens' groups, and they interpret and maintain standards of professional practice. Liaison relationships between the state Associations and the APA are a responsibility of the state and professional affairs staff in the APA Central Office.

HOW APA SETS EDUCATIONAL AND PROFESSIONAL STANDARDS

The Education and Training Board is responsible for establishing educational standards and for the formal accreditation of doctoral training programs in clinical and counseling programs in the graduate schools of universities (see Appendix A), and internship programs in practicum agencies. This program of evaluation and accreditation is supported in part by a grant from the National Institute of Mental Health. The APA is a member of the National Commission for Accreditation. The APA maintains a professional staff for this activity in its central office.

The Board of Professional Affairs is responsible for the establishment, maintenance, and extension of high professional standards in psychology. It has active committees in the areas of mental health research and programs, clinical practice, insurance reimbursement, liaison with other mental health professions, and practice of psychology in schools and in industry. The APA maintains professional staff for these activities in its central office.

In 1960, the Association adopted standards recommended by the Board of Professional Affairs for members who wish to list themselves in the annual *American Psychological Association Directory* as being in private practice (see Appendix B).

The American Board of Examiners in Professional Psychology (ABEPP) was established by APA in 1947 to grant diplomate status, through examination, to those psychologists who have qualified themselves as advanced specialists in clinical, counseling, or industrial psychology (Kelley, Sanford, & Clark, 1961). As of December 1965, 1,359 APA members held diplomate status in clinical psychology, 259 in counseling psychology, and 177 in industrial psychology.

The promotion of informed discussion is one effective method for upgrading educational and professional standards and practice. With government grant support, the Association has planned and managed a number of conferences on the practice and evaluation of psychotherapy, rehabilitation, preventive mental health, clinical training, and graduate education and has published the proceedings (Lofquist, 1961; Moore, Ross, & Skodak, 1959; Raimy, 1950; Rubenstein & Parloff, 1959; Strother, 1957; Strupp & Luborsky, 1962; Wright, 1959; Zimet & Throne, 1965).

PERSONAL AND ORGANIZATIONAL CONTROLS GOVERNING THE PROFESSIONAL FUNCTIONING OF THE PSYCHOLOGIST

Psychologists are committed to the principle that the public welfare and the patient's and client's welfare take precedence in all professional relationships. Psychologists require of themselves that practice conform to the highest ethical standards. To this end, they have evolved a code of ethics and organizational mechanisms for the internal control of practice.

The Committee on Scientific and Professional Ethics and Conduct has the specific charge to develop and enforce principles and rules of ethical practice and procedure among members of the Association. The committee receives, investigates, and evaluates complaints against psychologists and takes appropriate action including probation or dismissal. (The most recent revision, 1963, of the publication *Ethical Standards of Psychologists* is included as Appendix C.)

State, county, and local psychological associations and societies also maintain ethics committees with similar operational functions. A professional member of the APA Central Office staff serves as a liaison officer to these other geographic units as well as secretary of the national Ethics Committee.

It is significant and of special interest to insurance carriers and consumers that in 5 years of professional liability insurance coverage of 2,229 members of APA, no cases have gone to trial in which the claimant has had a judgment rendered against the psychologist. (The total amount paid out by the insurer for the 5-year period was approximately \$15,000, all spent on legal fees.)

HOW STATES REGULATE THE PRACTICE OF PSYCHOLOGY

In addition to the APA standards for training and professional practice and the provision for internal control of professional practice, the practice of psychology is governed in 44 of the 50 states and in the District of Columbia either by state law or by the affiliated state psychological association. (See Appendix D.) As of June 1965, these states contained 93% of the population of the country. Twenty-eight of the states, representing 55% of the population of the United States, have licensing or certification laws governing psychology; and 16 states plus the District of Columbia, representing 38% of the national population, have nonstatutory regulation by state association. In addition, four Canadian provinces have laws governing the practice of the profession.

In the remaining six states in which neither statutory certification nor certification by the state association is currently in operation, an interim procedure for the identification of qualified psychologists has been set up in keeping with the "definition of a psychologist for insurance purposes" passed by the Council of Representatives of the American Psychological Association (see pp. 12).

The American Psychological Association has assisted in the organization of the American Association of State Psychology Boards, a national group of representatives of the official State Boards of Examiners in Psychology. This group is actively engaged in improving communication among the state boards, dealing with problems of reciprocal endorsement, and establishing national examinations.

WHAT IS A MENTAL OR EMOTIONAL DISORDER AND HOW IS IT TREATED?

Mental and emotional disorders are broad terms used to describe various types of personality malfunctions or behavior disturbance. Most authorities agree that many of these disorders follow from psychological conflict within the person's interpersonal relationships in daily life. In some instances, physico-chemical disorders precipitate the psychological condition. The majority of conditions which come to the attention of all mental health specialists are of the former type. When psychological conflict is prolonged and severe, the individual's thinking, motivation, emotional expression, memory, ability to learn, and other psychological functions may gradually become impaired. Eventually such disturbances may produce obvious symptoms such as peculiar ideas, odd behavior, unusual sensory experiences, unrealistic fears, or other maladaptive reactions.

The major focus for the treatment of mental or emotional disorders, especially on an out-patient basis, is upon assisting the individual in resolving the underlying conflicts which have created the condition and in restoring or developing a viable capacity for human relationships. The most frequent treatment is psychotherapy. Thus, in the Group Health Insurance study of the out-patient treatment of mental disturbance "nearly all patients (96%) had individual psychotherapy" (Avnet, 1962). The psychologist applies the established principles of psychology and behavior modification to the amelioration of the psychological disorder. This may take the form of individual psychotherapy, group psychotherapy, milieu therapy, or some form of situational modification. Other forms of treatment such as shock treatment, chemotherapy, and the like, which are not the direct responsibility of the psychologist since they are administered by medical personnel, are used less frequently in out-patient settings. When they are used, it is in the expectation that they will result in improved communication with the patient so that psychotherapy can more effectively take place.

WHO PROVIDES DIAGNOSTIC AND PSYCHOTHERAPEUTIC SERVICES?

The clinical psychologist is a psychological specialist and the psychiatrist is a medical specialist, both of whom are concerned with the diagnosis and treatment of mental and emotional disorders.

Both the psychologist and the psychiatrist provide psychotherapeutic services (Ogg, 1962). The training of the psychologist has a behavioral science base and

culminates in a doctoral degree. The training of the psychiatrist has a biological science base and leads to a medical degree. Both may obtain postdoctoral training in psychotherapy, frequently at the same institutions. The faculties of these postdoctoral training centers generally include both psychologists and psychiatrists.

Each profession has developed some areas of specialization. Psychologists, as a result of training in psychological processes and measurement, have developed the use of diagnostic psychological testing; psychiatrists, as a product of their medical training and legal responsibility, may engage in physical and drug therapies (Ogg, 1961; Ross & Lockman, 1965). It is incumbent upon a psychologist (see Appendix C, Principal 2b) to refer a patient to a medical practitioner where a question of medical diagnosis or treatment is involved.

WHO IS A QUALIFIED PSYCHOLOGIST FOR INSURANCE REIMBURSEMENT?

The APA Council of Representatives has approved the following statement (APA, 1962) applicable to the reimbursement of psychologists under the provisions of insurance contracts:

"The properly qualified professional psychologist has specialized knowledge and skills with which to render psychological services to clients with appropriately selected problems without routinely involving other professions or service groups in order to accomplish the maximum benefit for clients with such selected problems. In taking this position, it is recognized that such a policy is to be carried out in conformity with principles set forth in *Ethical Standards of Psychologists, Psychology and Its Relations with Other Professions*, the policies of the APA Education and Training Board governing evaluation of training programs, and of ABEPP with respect to its diploma.

"When an individual has a claim for evaluative or therapeutic services compensable under an insurance contract, and such services may be provided by a qualified psychologist, for purposes of reimbursement a psychologist shall be defined as a person who qualifies in any one of the following categories:

"1. in those states where statutory licensure or certification exists, the holding of a valid credential (as legally specified) is deemed sufficient to define a psychologist for purposes of reimbursement by insurance; or

"2. in those states where statutory licensure or certification does not exist, the holding of valid, nonstatutory (professional) certification established by the state psychological association affiliated with the American Psychological Association, is deemed acceptable; or

"3. in those states where neither statutory nor nonstatutory licensure or certification exists, a statement of qualification by a committee established for the purpose by the state psychological association affiliated with the American Psychological Association or, in the absence of such a committee, the holding of a diploma in the appropriate specialty awarded by the American Board of Examiners in Professional Psychology, is deemed acceptable."

HOW MANY PSYCHOLOGISTS ARE ENGAGED IN ACTIVITIES RELATED TO MENTAL HEALTH?

Based on recent manpower data collected by the National Register of Scientific and Technical Personnel and by the National Institute of Mental Health, it is estimated (Brayfield, 1965) that approximately 8,000 psychologists provide some 13 million man-hours per year of clinical services such as diagnosis, treatment, administration, and consultation. Another 7,500 psychologists spend another 13 million man-hours per year of psychological effort, primarily teaching and research, related to mental health. Thus some 15,000-16,000 psychologists are active in the mental health field and contribute a total of approximately 26 million man-hours per year of work so defined, approximately the same amount of man-hours as is contributed annually by psychiatrists. It should be noted that much of this service (by both psychologists and psychiatrists) is performed in tax-supported institutions such as the Veterans Administration, state hospitals, community clinics, state medical schools, etc.

Data from the same sources indicate that, among clinical psychologists, approximately 1,200 are in full-time private practice and at least another 1,200 are in part-time private practice.

The geographic distribution and the experience qualifications of private practice psychologists are of interest.

Psychologists in private practice are concentrated in New York and California, particularly in the New York City metropolitan area and the Greater Los Angeles area. New Jersey, Illinois, and Pennsylvania are the next-ranking states.

Michigan and Florida, in particular, are growing in numbers of full-time private practitioners; part-time private practitioners may be found in most of the states.

Two-thirds of psychologists in private practice have between 5 and 19 years of experience and more than a fifth have 20 or more years. Psychologists rarely enter private practice upon completion of their university degree programs, which include a year of supervised internship, but instead obtain additional training and experience in postdoctoral institutes, hospitals, psychotherapy centers, and other clinical settings.

WHAT DOES TREATMENT BY PSYCHOLOGISTS COST?

Data on the cost of treatment are relatively scarce and vary with geography. However, there are a few studies that are informative.

In 1960 the Welfare Planning Council, Los Angeles region, published an exhaustive survey of the mental health problem in that community. This study showed that, in the case of the clinical psychologist, the typical patient was seen once a week for a period of a year and paid about \$15 per visit (Los Angeles Region Welfare Planning Council, 1960).

The Los Angeles data on the cost of treatment are supported by a 1960 report of the Division of Clinical Psychology of the New York State Psychological Association (1963). This survey indicated that fees for psychological services were most commonly in the vicinity of \$15 per session and ranged generally from \$10 to \$20 per session. Reports from other major urban areas confirm these findings.

In Minnesota, the state psychological association in 1964 recommended that \$20 per hour of service be used as a guideline. Informed data suggest that fees have risen generally since the 1960 surveys noted above and currently are averaging approximately \$20 per session ranging generally from \$15 to \$25 per session for individual psychotherapy.

AFFIRMATIVE ACTIONS FOR THE PRACTICE OF PSYCHOTHERAPY AND THE PROVISION OF OTHER MENTAL HEALTH SERVICES BY PSYCHOLOGISTS

In response to a concrete demand for his services, the psychologist has emerged as an autonomously functioning practitioner in the mental health area. Many official actions have affirmed this development:

1. The United States Court of Appeals has held that psychologists are qualified to render expert testimony in the field of mental disorder (Hanson, Cochran, & L'Hommedieu, 1962; Hoch & Darley, 1962).

2. State legislatures and administrative agencies have included psychotherapy in the definition of the practice of psychology (Kentucky House Bill No. 249, 1964; University of the State of New York, 1961).

3. State legislatures have rejected proposals for restricting the practice of psychotherapy to physicians.

4. Opinions of state legal officers (Michigan, New York) have held that the practice of psychotherapy is not restricted to physicians.¹

5. Educational institutions training psychologists in the practice of psychotherapy have received state charters.

6. Fees paid to psychologists for psychotherapeutic services are deductible for income tax purposes.

HOW THE FEDERAL GOVERNMENT AFFIRMS THE MENTAL HEALTH CONTRIBUTIONS OF PSYCHOLOGISTS

The Federal government recognizes the professional mental health contribution of psychologists in a variety of ways.

¹ In a decision rendered January 30, 1959, Charles Brind, Counsel for the New York State Education Department, the department responsible for administering the laws governing all professions in New York State, held that the use of the title "psychotherapy" was not restricted to physicians by the Medical Practices Act. This decision was arrived at following extensive hearings, at which representatives of the several professions active in the mental health field were heard.

Thomas M. Kavanagh, Attorney General of the State of Michigan, rendered an opinion on January 20, 1956, on the question of whether the practice of "psychotherapeutics" by psychologists constitutes the practice of medicine within the meaning of the Medical Practices Act of the State of Michigan. He concluded that: "Therapy as such is not prohibited by the Medical Practices Act, which covers only therapy medical in nature." Psychologists are not in violation of this act unless they "purport or attempt to cure any physical ailment by the laying on of hands, by magnetic suggestion, or other form of medical or surgical treatment."

More than 1,000 clinical psychologists hold appointments in Federal agencies and are engaged in a range of mental health services including the practice of psychotherapy.

Psychologists are widely used by the Federal government in consultative capacities. Approximately 450 psychologists serve as consultants to the Social Security Agency as vocational and/or clinical experts who evaluate the employability of claimants seeking compensation under disability laws. A similar number are consultants to the Veterans' Administration hospitals and clinics. Psychologists serve on the National Advisory Mental Health Council, the Council of the National Institute of Child Health and Human Development, and on training and research grant panels of the National Institute of Mental Health.

More than half of the grants for research made by the National Institute of Mental Health are for projects in which a psychologist is the principal investigator.

The U.S. Public Health Service advisory bulletin titled *Improving Mental Health Insurance Coverage* (NIMH, 1965), discussing health insurance benefits, suggests as one of the guiding principles that "increased recognition should be given to all the professional skills essential to treatment and rehabilitation." In elaboration of this principle it states: "Both the continuing development of the mental health treatment team and the present shortage of mental health personnel argue strongly for covering the services of all mental health disciplines, including the clinical psychologist, the psychiatric social worker, and the psychiatric nurse." The bulletin does not recommend or suggest that medical referral be required.

INSURANCE INDUSTRY PRECEDENTS AND EXPERIENCES

Insurance companies including, for example, Occidental Life, Liberty Mutual, Aetna, Metropolitan, Travelers, Western and Southern, Beneficial Standard, and Guardian Life have included provision in one or more insurance contracts for the diagnostic and therapeutic services of psychologists.

The effect of the inclusion of such provisions on claims costs is of considerable interest to both purchasers of insurance and to the carriers. No data have been reported which would indicate that the inclusion of services by psychologists in health insurance plans has resulted in any significant increase in claims costs. Information pertinent to this point is contained in a personal communication dated September 22, 1965, to Dr. Rogers H. Wright from Mr. Herbert Eagle, Vice-President of the Occidental Life Insurance Company of California, who wrote as follows:

"We offer this coverage in the group policies issued to the Pasadena and the Los Angeles City Schools.

"The Pasadena group policy was effective April 1, 1964. Up to present time, no claims involving the services of a professional psychologist have been presented to us.

"The group policy for the Los Angeles Unified School District was effective April 1, 1964. Since the effective date, we have received four claims involving the services of a psychologist. . . .

"We do feel that such coverage, if properly underwritten, is warranted from a business standpoint and is desirable from a social one."

Relevant to the question of costs are the reports of two preliminary studies conducted at Kaiser-Permanente in San Francisco, one covering a span of 3 years (Cummings, Kahn, & Sparkman in Greenfield, 1964) and another covering 6 years (Follette & Cummings, 1966). These studies revealed that high medical users significantly reduced their utilization of medical facilities following psychotherapy. Viewed from the overall perspective of total insurance costs, the costs of providing psychotherapy were considerably offset by the savings in general medical costs.

WHAT IS THE PUBLIC INTEREST?

The Joint Commission on Mental Illness and Health of the U.S. Congress, which consisted of representatives of all the major groups functioning in the mental health field (including the American Psychological Association and the American Psychiatric Association), after intensive study of the "questions of authority, professional prerogatives, and qualifications involved in the treatment of the mentally ill," concluded that the "only principle than can satisfy all interested parties, including the public, is one of *individual competence* to undertake a given approach to a patient." This applies equally to psychologists and psychiatrists and other mental health professionals (Joint Commission, 1961).

The Joint Commission documented the need to increase the supply of competent practitioners in all the mental health professions, if we are to begin to cope with the problem of mental and emotional disorders. Programs designed to provide treatment for these disorders which limit the patient's access to even the present limited supply of treatment personnel and services are contrary to the recommendations of the Joint Commission.

The U.S. Senate recently (1965) affirmed the principle of "competence" advocated by the Joint Commission. Subsequent to its consideration of H.R. 2985 and S. 513, the "Initial Staffing for Community Mental Health Centers" bills,² the Senate Committee on Labor and Public Welfare reported the legislation out favorably and stated for the record (S. Rep. No. 366, 89th Cong., 1st Sess., p. 4):

"There is no intent in any way in this bill to discriminate against any mental health professional group from carrying out its full potential within the realm of its recognized competence. Even further it is hoped that new and innovative tasks and roles will evolve from the broadly-based concept of the community mental health services. Specifically, overall leadership of a community mental health center program may be carried out by any one of the major mental health professions. Many professions have vital roles to play in the prevention, treatment, and rehabilitation of patients with mental illness."

Dr. Stanley F. Yolles, Director, National Institute of Mental Health, has affirmed this view (Yolles, 1966).

It is in this public interest context that the question of reimbursement under insurance contracts for services performed by psychologists in the treatment of mental and emotional disorders must be viewed.

The definition of the coverage for which benefits are provided may be a subject for negotiation between the insurance company and the consumer. However, when diagnosis and treatment of mental and emotional disorders are covered, it is clearly in the interest of adequate care and public service that unrestricted access to all sources of qualified professional assistance should be provided.

A serious public interest question is raised when private insurance companies exclude from reimbursement for services an entire profession which, by virtue of scientific and professional training and experience and community acceptance, has demonstrated its responsibility and competence for the care of conditions for which benefits are provided in a contract. In fact, a legal issue, based on anti-trust legislation, may well be involved.

When private carriers single out one profession—medicine—and ignore another—psychology—for reimbursement for services, they are inadvertently, but nevertheless effectively, acting in the role of a licensing or regulatory body. This role is properly reserved to state or Federal bodies.

As a matter of the larger public interest, then, and as a matter of responsible relations between a private insurance carrier and its consumers, a policyholder should have the right to choose freely from among those practitioners who are qualified to provide the services for those conditions which are covered in the contract. Thus persons covered by insurance contracts should have unincumbered access to the services of psychologists in programs designed to provide treatment for mental and emotional disorders.

A FINAL WORD

The American Psychological Association is prepared to consult with the members of the insurance industry and with consumer groups on various aspects of insurance coverage in the mental health field.

It recognizes that the experience of insurance carriers in covering costs of care for mental and emotional disorders and illness under policies is scanty and often inconclusive and that sound data would be of benefit to them and to the public.

It recognizes that consumer groups seek to inform themselves regarding the nature of mental and emotional disorders, the types and sources of high quality professional care, and effective ways of meeting their needs.

It believes that the knowledge and experience of psychologists can contribute importantly to the practical resolution of the problems involved in providing insurance protection for mental and emotional disorders.

To these ends, we invite requests for collaborative efforts.

Inquiries may be addressed to the Administrative Officer, State and Professional Affairs, American Psychological Association, 1200 Seventeenth Street, N.W., Washington, D.C. 20036.

²This legislation was signed by the President in August 1965 as Public Law 89-105.

APPENDIX A¹APA-APPROVED DOCTORAL PROGRAMS IN CLINICAL AND IN COUNSELING
PSYCHOLOGY: 1965

(By Sherman Ross, APA Education and Training Board)

On the recommendation of the Committee on Evaluation, the Education and Training Board has recommended, and the Board of Directors of the American Psychological Association has approved the doctoral programs in clinical psychology and in counseling psychology that are conducted by the institutions listed below. In the institutions listed, the approved programs are directed by the department of psychology unless otherwise indicated. Programs that have not requested evaluation and programs that have been evaluated but not approved are not included in the list. The criteria for evaluating these programs can be obtained from the Executive Secretary of the Education and Training Board.

Inclusion of an institution in these lists indicates approval of doctoral programs in clinical psychology and in counseling psychology only. Inclusion or noninclusion carries no implications for other graduate programs in psychology or for programs of graduate education in other disciplines.

The institutions listed below have been reported to the United States Public Health Service, to the Veterans Administration, and to the Surgeon General's Office, Department of the Army, as conducting at the present time approved programs of doctoral training in the areas indicated.

CLINICAL PSYCHOLOGY

Adelphi University	Nebraska, University of
Alabama, University of	New York, State University of (Buffalo)
Arizona State University	New York University, Graduate School
Arizona, University of	of Arts and Sciences
Boston University	North Carolina, University of
California, University of (Berkeley)	Northwestern University
California, University of (Los Angeles)	Ohio State University
Catholic University of America	Oklahoma, University of
Chicago, University of	Oregon, University of
Cincinnati, University of	Pennsylvania State University
Clark University	Pennsylvania, University of
Colorado, University of	Pittsburgh, University of
Connecticut, University of	Purdue University
Denver, University of	Rochester, University of
Duke University	Rutgers—The State University
Florida State University	St. Louis University
Florida, University of	Southern California, University of
Fordham University	Southern Illinois University
George Peabody College	Stanford University
Harvard University, Department of	Syracuse University
Social Relations	Teachers College, Columbia University
Houston, University of	Temple University
Illinois, University of	Tennessee, University of
Indiana University	Texas, University of
Iowa, State University of	Utah, University of
Kansas, University of	Vanderbilt University
Kentucky, University of	Washington State University
Louisiana State University	Washington, University of
Loyola University (Chicago)	Washington University (St. Louis)
Maryland, University of	Wayne State University
Massachusetts, University of	Western Reserve University
Michigan State University	Wisconsin, University of
Michigan, University of	Yale University
Minnesota, University of	Yeshiva University
Missouri, University of	

¹ Reprinted from the *American Psychologist*, September 1965. Copyrighted by the American Psychological Association, Inc., September 1965.

COUNSELING PSYCHOLOGY

Boston University	Nebraska, University of
California, University of (Los Angeles)	New York, State University of (Buffalo)
Catholic University of America	Ohio State University
Florida, University of	Oregon, University of, Departments of
George Peabody College	Education and of Psychology
Illinois, University of	Purdue University
Iowa, State University of	Southern Illinois University
Kansas, University of, Department of	Teachers College, Columbia University
Education and of Psychology	Temple University
Maryland, University of	Texas Technological College
Michigan, University of	Texas, University of, Department of
Minnesota, University of, Department	Education and of Psychology
of Psychology, College of Liberal Arts	Utah, University of, Departments of
Minnesota, University of, Department	Psychology and of Educational
of Educational Psychology, College	Psychology
of Education	
Missouri, University of, Departments	
of Education and of Psychology	

APPENDIX B¹

STANDARD FOR APA DIRECTORY LISTINGS OF PRIVATE PRACTICE

Private practice is defined as follows: A psychologist in any area of psychology (clinical, industrial, social, experimental, etc.) is in independent private practice when he assumes independent professional responsibility for services to and relationships with a client or clients without the mediating controls of institutional or group membership.

Two sets of standards have been proposed. One for the guidance of APA members who have been elected to the association since 1958, the other for the guidance of those who were Fellows or Members of the APA as of January 1, 1958, the effective date of the current APA membership standards. The standards are as follows:

The following shall constitute the minimum standards for representing oneself (by means of *Directory* listings, announcements of practice, and the like) as engaging in the independent private practice of psychology (whether full-time or part-time), except in the case of individuals who as of January 1, 1958 were Fellows or Members of the APA:

1. Possession of the ABEPP Diploma in the field of psychology in which the individual engages in independent private practice; or

2. A PhD degree, based in part on a doctoral dissertation, conferred by a department of psychology which at the time the degree was awarded met the standards of the APA, or the equivalent of such a degree; and at least three years of paid full-time experience, or its equivalent in part-time paid experience (at the minimum rate of fifteen hours per week) to be obtained subsequent to two years of graduate study and in the general field of specialization in which the psychologist is engaged in private practice, such experience to have been (a) in an institutional or group setting, and (b) under direct supervision, preferably by a psychologist, or by another professional worker of recognized standing.

Individuals who became Fellows or Members of the APA on or before January 1, 1958 and who, in the 1962 and following editions of the *Directory*, wish to include a private practice listing, shall fulfill one of the following minimum standards:

1. Possess the ABEPP Diploma in the field of psychology in which the individual engages in independent private practice; or

2. Possess a PhD degree (or an equivalent doctoral degree) in psychology from a recognized university and at least two years of paid full-time experience (or its equivalent in part-time paid experience at the minimum rate of fifteen hours per week) in an institutional or group setting; or

3. Have two years of graduate training in psychology at a recognized university or college and at least three years of paid full-time experience (or its equivalent).

¹ Reprinted from the *American Psychologist*, December 1960. Copyrighted by the American Psychological Association, Inc., 1960.

lent in part-time paid experience at the minimum rate of fifteen hours per week) in an institutional or group setting; or

4. Have two years of graduate training in psychology at a recognized university or college and at least five years of paid full-time experience (or its equivalent in part-time experience at the minimum rate of fifteen hours per week) in independent private practice.

As used in the foregoing statements, group practice is defined as the cooperative practice of two or more psychologists (or allied professional workers) who (a) share some professional responsibilities together, (b) engage in some distinct group functions (such as common referral services and regular case presentations and seminars), and (c) include as members of the group at least one psychologist who could qualify, under the above provisions, as an independent private practitioner.

APPENDIX C¹

ETHICAL STANDARDS OF PSYCHOLOGISTS

The psychologist believes in the dignity and worth of the individual human being. He is committed to increasing man's understanding of himself and others. While pursuing this endeavor, he protects the welfare of any person who may seek his service or of any subject, human or animal, that may be the object of his study. He does not use his professional position or relationships, nor does he knowingly permit his own services to be used by others, for purposes inconsistent with these values. While demanding for himself freedom of inquiry and communication, he accepts the responsibility this freedom confers: for competence where he claims it, for objectivity in the report of his findings, and for consideration of the best interests of his colleagues and of society.

SPECIFIC PRINCIPLES

Principle 1. Responsibility.—The psychologist,² committed to increasing man's understanding of man, places high value on objectivity and integrity, and maintains the highest standards in the services he offers.

a. As a scientist, the psychologist believes that society will be best served when he investigates where his judgment indicates investigation is needed; he plans his research in such a way as to minimize the possibility that his findings will be misleading; and he publishes full reports of his work, never discarding without explanation data which may modify the interpretation of results.

b. As a teacher, the psychologist recognizes his primary obligation to help others acquire knowledge and skill, and to maintain high standards of scholarship.

c. As a practitioner, the psychologist knows that he bears a heavy social responsibility because his work may touch intimately the lives of others.

Principle 2. Competence.—The maintenance of high standards of professional competence is a responsibility shared by all psychologists, in the interest of the public and of the profession as a whole.

a. Psychologists discourage the practice of psychology by unqualified persons and assist the public in identifying psychologists competent to give dependable professional service. When a psychologist or a person identifying himself as a psychologist violates ethical standards, psychologists who know firsthand of such activities attempt to rectify the situation. When such a situation cannot be dealt with informally, it is called to the attention of the appropriate local, state, or national committee on professional ethics, standards, and practices.

b. The psychologist recognizes the boundaries of his competence and the limitations of his techniques and does not offer services or use techniques that fail to meet professional standards established in particular fields. The psychologist who engages in practice assists his client in obtaining profes-

¹ Reprinted (and edited) from the *American Psychologist*, January 1963. Copyrighted by the American Psychological Association, Inc., January 1963.

² A student of psychology who assumes the role of psychologist shall be considered a psychologist for the purpose of this code of ethics.

sional help for all important aspects of his problem that fall outside the boundaries of his own competence. This principle requires, for example, that provision be made for the diagnosis and treatment of relevant medical problems and for referral to or consultation with other specialists.

c. The psychologist in clinical work recognizes that his effectiveness depends in good part upon his ability to maintain sound interpersonal relations, that temporary or more enduring aberrations in his own personality may interfere with this ability or distort his appraisals of others. There he refrains from undertaking any activity in which his personal problems are likely to result in inferior professional services or harm to a client; or, if he is already engaged in such an activity when he becomes aware of his personal problems, he seeks competent professional assistance to determine whether he should continue or terminate his services to his client.

Principle 3. Moral and Legal Standards.—The psychologist in the practice of his profession shows sensible regard for the social codes and moral expectations of the community in which he works, recognizing that violations of accepted moral and legal standards on his part may involve his clients, students, or colleagues in damaging personal conflicts, and impugn his own name and the reputation of his profession.

Principle 4. Misrepresentation.—The psychologist avoids misrepresentation of his own professional qualifications, affiliations, and purposes, and those of the institutions and organizations with which he is associated.

a. A psychologist does not claim either directly or by implication professional qualifications that differ from his actual qualifications, nor does he misrepresent his affiliation with any institution, organization, or individual, nor lead others to assume he has affiliations that he does not have. The psychologist is responsible for correcting others who misrepresent his professional qualifications or affiliations.

b. The psychologist does not misrepresent an institution or organization with which he is affiliated by ascribing to its characteristics that it does not have.

c. A psychologist does not use his affiliation with the American Psychological Association or its Divisions for purposes that are not consonant with the stated purposes of the Association.

d. A psychologist does not associate himself with or permit his name to be used in connection with any services or products in such a way as to misrepresent them, the degree of his responsibility for them, or the nature of his affiliation.

Principle 5. Public Statements.—Modesty, scientific caution, and due regard for the limits of present knowledge characterize all statements of psychologists who supply information to the public, either directly or indirectly.

a. Psychologists who interpret the science of psychology or the services of psychologists to clients or to the general public have an obligation to report fairly and accurately. Exaggeration, sensationalism, superficiality, and other kinds of misrepresentation are avoided.

b. When information about psychological procedures and techniques are given, care is taken to indicate that they should be used only by persons adequately trained in their use.

c. A psychologist who engages in radio or television activities does not participate in commercial announcements recommending purchase or use of a product.

Principle 6. Confidentiality.—Safeguarding information about an individual that has been obtained by the psychologist in the course of his teaching, practice, or investigation is a primary obligation of the psychologist. Such information is not communicated to others unless certain important conditions are met.

a. Information received in confidence is revealed only after most careful deliberation and when there is clear and imminent danger to an individual or to society, and then only to appropriate professional workers or public authorities.

b. Information obtained in clinical or consulting relationships, or evaluative data concerning children, students, employees, and others are discussed only for professional purposes and only with persons clearly concerned with the case. Written and oral reports should present only data germane to the purposes of the evaluation; every effort should be made to avoid undue invasion of privacy.

c. Clinical and other materials are used in classroom teaching and writing only when the identity of the persons involved is adequately disguised.

d. The confidentiality of professional communications about individuals is maintained. Only when the originator and other persons involved give their express permission is a confidential professional communication shown to the individual concerned. The psychologist is responsible for informing the client of the limits of the confidentiality.

e. Only after explicit permission has been granted is the identity of research subjects published. When data have been published without permission for identification, the psychologist assumes responsibility for adequately disguising their sources.

f. The psychologist makes provisions for the maintenance of confidentiality in the preservation and ultimate disposition of confidential records.

Principle 7. Client Welfare.—The psychologist respects the integrity and protects the welfare of the person or group with whom he is working.

a. The psychologist in industry, education, and other situations in which conflicts of interest may arise among various parties, as between management and labor, or between the client and employer of the psychologist, defines for himself the nature and direction of his loyalties and responsibilities and keeps all parties concerned informed of these commitments.

b. When there is a conflict among professional workers, the psychologist is concerned primarily with the welfare of any client involved and only secondarily with the interest of his own professional group.

c. The psychologist attempts to terminate a clinical or consulting relationship when it is reasonably clear to the psychologist that the client is not benefiting from it.

d. The psychologist who asks that an individual reveal personal information in the course of interviewing, testing, or evaluation, or who allows such information to be divulged to him, does so only after making certain that the responsible person is fully aware of the purposes of the interview, testing, or evaluation and of the ways in which the information may be used.

e. In cases involving referral, the responsibility of the psychologist for the welfare of the client continues until this responsibility is assumed by the professional person to whom the client is referred or until the relationship with the psychologist making the referral has been terminated by mutual agreement. In situations where referral, consultation, or other changes in the conditions of the treatment are indicated and the client refuses referral, the psychologist carefully weighs the possible harm to the client, to himself, and to his profession that might ensue from continuing the relationship.

f. The psychologist who requires the taking of psychological tests for didactic classification, or research purposes protects the examinees by insuring that the tests and test results are used in a professional manner.

g. When potentially disturbing subject matter is presented to students, it is discussed objectively, and efforts are made to handle constructively any difficulties that arise.

h. Care must be taken to insure an appropriate setting for clinical work to protect both client and psychologist from actual or imputed harm and the profession from censure.

i. In the use of accepted drugs for therapeutic purposes special care needs to be exercised by the psychologist to assure himself that the collaborating physician provides suitable safeguards for the client.

Principle 8. Client Relationship.—The psychologist informs his prospective client of the important aspects of the potential relationship that might affect the client's decision to enter the relationship.

a. Aspects of the relationship likely to affect the client's decision include the recording of an interview, the use of interview material for training purposes, and observation of an interview by other persons.

b. When the client is not competent to evaluate the situation (as in the case of a child), the person responsible for the client is informed of the circumstances which may influence the relationship.

c. The psychologist does not normally enter into a professional relationship with members of his own family, intimate friends, close associates, or others whose welfare might be jeopardized by such a dual relationship.

Principle 9. Impersonal Services.—Psychological services for the purpose of diagnosis, treatment, or personalized advice are provided only in the context of a professional relationship, and are not given by means of public lectures

or demonstrations, newspaper or magazine articles, radio or television programs, mail, or similar media.

a. The preparation of personnel reports and recommendations based on test data secured solely by mail is unethical unless such appraisals are an integral part of a continuing client relationship with a company, as a result of which the consulting psychologist has intimate knowledge of the client's personnel situation and can be assured thereby that his written appraisals will be adequate to the purpose and will be properly interpreted by the client. These reports must not be embellished with such detailed analyses of the subject's personality traits as would be appropriate only after intensive interviews with the subject. The reports must not make specific recommendations as to employment or placement of the subject which go beyond the psychologist's knowledge of the job requirements of the company. The reports must not purport to eliminate the company's need to carry on such other regular employment or personnel practices as appraisal of the work history, checking of references, past performance in the company.

Principal 10. Announcement of Services.—A psychologist adheres to professional rather than commercial standards in making known his availability for professional services.

a. A psychologist does not directly solicit clients for individual diagnosis or therapy.

b. Individual listings in telephone directories are limited to name, highest relevant degree, certification status, address, and telephone number. They may also include identification in a few words of the psychologist's major areas of practice; for example, child therapy, personnel selection, industrial psychology. Agency listings are equally modest.

c. Announcements of individual private practice are limited to a simple statement of the name, highest relevant degree, certification or diplomate status, address, telephone number, office hours, and a brief explanation of the types of services rendered. Announcements of agencies may list names of staff members with their qualifications. They conform in other particulars with the same standards as individual announcements, making certain that the true nature of the organization is apparent.

d. A psychologist or agency announcing nonclinical professional services may use brochures that are descriptive of services rendered but not evaluative. They may be sent to professional persons, schools, business firms, government agencies, and other similar organizations.

e. The use in a brochure of "testimonials from satisfied users" is unacceptable. The offer of a free trial of services is unacceptable if it operates to misrepresent in any way the nature of the efficacy of the services rendered by the psychologist. Claims that a psychologist has unique skills or unique devices not available to others in the profession are made only if the special efficacy of these unique skills or devices has been demonstrated by scientifically acceptable evidence.

f. The psychologist must not encourage (nor, within his power, even allow) a client to have exaggerated ideas as to the efficacy of services rendered. Claims made to clients about the efficacy of his services must not go beyond those which the psychologist would be willing to subject to professional scrutiny through publishing his results and his claims in a professional journal.

Principle 11. Interprofessional Relations.—A psychologist acts with integrity in regard to colleagues in psychology and in other professions.

a. A psychologist does not normally offer professional services to a person receiving psychological assistance from another professional worker except by agreement with the other worker or after the termination of the client's relationship with the other professional worker.

b. The welfare of clients and colleagues requires that psychologists in joint practice or corporate activities make an orderly and explicit arrangement regarding the conditions of their association and its possible termination. Psychologists who serve as employers of other psychologists have an obligation to make similar appropriate arrangements.

Principle 12. Remuneration.—Financial arrangements in professional practice are in accord with professional standards that safeguard the best interest of the client and the profession.

a. In establishing rates for professional services, the psychologist considers carefully both the ability of the client to meet the financial burden and the charges made by other professional persons engaged in comparable

work. He is willing to contribute a portion of his services to work for which he receives little or no financial return.

b. No commission or rebate or any other form of remuneration is given or received for referral of clients for professional services.

c. The psychologist in clinical or counseling practice does not use his relationship with clients to promote, for personal gain or the profit of an agency, commercial enterprises of any kind.

d. A psychologist does not accept a private fee or any other form of remuneration for professional work with a person who is entitled to his services through an institution or agency. The policies of a particular agency may make explicit provision for private work with its clients by members of its staff, and in such instances the client must be fully appraised of all policies affecting him.

Principle 13. Test Security.—Psychological tests and other assessment devices, the value of which depends in part on the naivete of the subject, are not reproduced or described in popular publications in ways that might invalidate the techniques. Access to such devices is limited to persons with professional interests who will safeguard their use.

a. Sample items made up to resemble those of tests being discussed may be reproduced in popular articles and elsewhere, but scorable tests and actual test items are not reproduced except in professional publications.

b. The psychologist is responsible for the control of psychological tests and other devices and procedures used for instruction when their value might be damaged by revealing to the general public their specific contents or underlying principles.

Principle 14. Test Interpretation.—Test scores, like test materials, are released only to persons who are qualified to interpret and use them properly.

a. Materials for reporting test scores to parents, or which are designed for self-appraisal purposes in schools, social agencies, or industry are closely supervised by qualified psychologists or counselors with provisions for referring and counseling individuals when needed.

b. Test results or other assessment data used for evaluation or classification are communicated to employers, relatives, or other appropriate persons in such a manner as to guard against misinterpretation or misuse. In the usual case, an interpretation of the test result rather than the score is communicated.

c. When test results are communicated directly to parents and students, they are accompanied by adequate interpretive aids or advice.

Principle 15. Test Publication.—Psychological tests are offered for commercial publication only to publishers who present their tests in a professional way and distribute them only to qualified users.

a. A test manual, technical handbook, or other suitable report on the test is provided which describes the method of constructing and standardizing the test, and summarizes the validation research.

b. The populations for which the test has been developed and the purposes for which it is recommended are stated in the manual. Limitations upon the test's dependability, and aspects of its validity on which research is lacking or incomplete, are clearly stated. In particular, the manual contains a warning regarding interpretations likely to be made which have not yet been substantiated by research.

c. The catalog and manual indicate the training or professional qualifications required for sound interpretation of the test.

d. The test manual and supporting documents take into account the principles enunciated in the *Standards for Educational and Psychological Tests and Manuals*.

e. Test advertisements are factual and descriptive rather than emotional and persuasive.

Principle 16. Research Precautions.—The psychologist assumes obligations for the welfare of his research subjects, both animal and human.

a. Only when a problem is of scientific significance and it is not practicable to investigate it in any other way is the psychologist justified in exposing research subjects, whether children or adults, to physical or emotional stress as part of an investigation.

b. When a reasonable possibility of injurious aftereffects exists, research is conducted only when the subjects or their responsible agents are fully informed of this possibility and agree to participate nevertheless.

c. The psychologist seriously considers the possibility of harmful after-effects and avoids them, or removes them as soon as permitted by the design of the experiment.

d. A psychologist using animals in research adheres to the provisions of the Rules Regarding Animals, drawn up by the Committee on Precautions and Standards in Animal Experimentation and adopted by the American Psychological Association.

e. Investigations of human subjects using experimental drugs (for example: hallucinogenic, psychotomimetic, psychedelic, or similar substances) should be conducted only in such settings as clinics, hospitals, or research facilities maintaining appropriate safeguards for the subjects.

Principle 17. Publication Credit.—Credit is assigned to those who have contributed to a publication, in proportion to their contribution, and only to these.

a. Major contributions of a professional character, made by several persons to a common project, are recognized by joint authorship. The experimenter or author who has made the principal contribution to a publication is identified as the first listed.

b. Minor contributions of a professional character, extensive clerical or similar nonprofessional assistance, and other minor contributions are acknowledged in footnotes or in an introductory statement.

c. Acknowledgment through specific citations is made for unpublished as well as published material that has directly influenced the research or writing.

d. A psychologist who compiles and edits for publication the contributions of others publishes the symposium or report under the title of the committee or symposium, with his own name appearing as chairman or editor among those of the other contributors or committee members.

Principle 18. Responsibility Toward Organization.—A psychologist respects the rights and reputation of the institute or organization with which he is associated.

a. Materials prepared by a psychologist as a part of his regular work under specific direction of his organization are the property of that organization. Such materials are released for use or publication by a psychologist in accordance with policies of authorization, assignment of credit, and related matters which have been established by his organization.

b. Other material resulting incidentally from activity supported by any agency, and for which the psychologist rightly assumes individual responsibility, is published with disclaimer for any responsibility on the part of the supporting agency.

Principle 19. Promotional Activities.—The psychologist associated with the development or promotion of psychological devices, books, or other products offered for commercial sale is responsible for ensuring that such devices, books, or products are presented in a professional and factual way.

a. Claims regarding performance, benefits, or results are supported by scientifically acceptable evidence.

b. The psychologist does not use professional journals for the commercial exploitation of psychological products, and the psychologist-editor guards against such misuse.

c. The psychologist with a financial interest in the sale or use of a psychological product is sensitive to possible conflict of interest in his promotion of such products and avoids compromise of his professional responsibilities and objectives.

APPENDIX D

STATE REGULATION OF THE PRACTICE OF PSYCHOLOGY

STATES AND PROVINCES WITH LAWS

Alabama	Georgia	Minnesota	Utah
Arizona	Idaho	Nevada	Virginia
Arkansas	Illinois	New Hampshire	Washington
California	Kentucky	New Mexico	Wyoming
Colorado	Louisiana	New York	Alberta
Connecticut	Maine	Oklahoma	Ontario
Delaware	Maryland	Oregon	Quebec
Florida	Michigan	Tennessee	Saskatchewan

STATES WITH NONSTATUTORY PROGRAMS, AUGUST 1965

Iowa	Montana	Ohio	South Dakota
Kansas	Nebraska	Pennsylvania	Texas
Massachusetts	New Jersey	Rhode Island	West Virginia
Missouri	North Dakota	South Carolina	Wisconsin
	District of Columbia		

REFERENCES

- AMERICAN PSYCHOLOGICAL ASSOCIATION. Proceedings of the Seventieth Annual Business Meeting. *American Psychologist*, 1962, 17, 855-856.
- AVNET, HELEN H. *Psychiatric insurance: Financing short-term ambulatory treatment*. New York: New York Group Health Insurance, Inc. 1962.
- BRAYFIELD, A. H. Human effectiveness. *American Psychologist*, 1956, 20, 645-651.
- CUMMINGS, N. A. KAHN, B. I., & SPARKMAN, B. Psychotherapy and medical utilization. As cited in Greenfield, Margaret, *Providing for mental illness*. Berkeley: Berkeley Institute of Government Studies, University of California, 1964.
- FOLLETTE, W., & CUMMINGS, N. A. *Psychiatric services and medical utilization prepaid health plan setting*. Health Economic Monograph. Washington, D.C.: United States Public Health Service, 1966. In press.
- HANSON, A. B., COCHRAN, D. F., & L'HOMMEDIEU, S. J. Brief for American Psychological Association, Amicus Curiae, in the United States Court of Appeals for the District of Columbia Circuit. No. 16,306. *Vincent E. Jenkins v. U.S.A.*, 1962.
- HOCH, E. L., & DARLEY, J. G. Case at law. *American Psychologist*, 1962, 17, 623-654.
- JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH. *Action for mental health*. New York: Basic Books, 1961. P. 248.
- KELLEY, N. H., SANFORD, F. H., & CLARK, K. E. The meaning of the ABEPP diploma. *American Psychologists*, 1961, 16, 132-141.
- LOFQUIST, L. H. (Ed.) *Psychological research and rehabilitation*. (Conference Report, Miami Beach, Florida, 1960) Washington, D.C.: American Psychological Association, 1961.
- LOS ANGELES REGION WELFARE PLANNING COUNCIL. *Los Angeles County surveys its mental health services*. Los Angeles: Author, 1960, P. 11.
- NATIONAL INSTITUTE OF MENTAL HEALTH. *Improving mental health insurance coverage*. (Public Health Service Publication 1253). Washington, D.C.; United States Department of Health, Education, and Welfare, August 1965.
- NEW YORK STATE PSYCHOLOGICAL ASSOCIATION, COMMITTEE ON PRIVATE PRACTICE OF THE DIVISION OF CLINICAL PSYCHOLOGY. *The clinical psychologist in the private practice of psychotherapy in New York State*. New York: Author, 1963.
- OGG, E. *Psychologists in action*. (Public Affairs Pamphlet No. 229) (5th ed.) New York: Public Affairs Committee, 1961.
- OGG, E. *Psychotherapy—A helping process*. (Public Affairs Pamphlet No. 329) (2nd ed.) New York: Public Affairs Committee, 1962.
- RAIMY, V. C. (Ed.) *Training in clinical psychology*. New York: Prentice-Hall, 1950.
- ROE, A., GUSTAD, J. W., MOORE, B. V., ROSS, S. & SKODAK, M. (Eds.) *Graduate education in psychology*. Washington, D.C.: American Psychological Association, 1959.
- ROSS, S., & LOCKMAN, R. F. *Career in psychology*. Washington, D.C.: American Psychological Association, 1965.
- RUBENSTEIN, E. A., & PARLOFF, M. B. (Eds.) *Research in psychotherapy*. (Proceedings of a Conference) Washington, D.C., 1958. Washington, D.C.: American Psychological Association, 1959.
- STROTHER, C. R. (Ed.) *Psychology and mental health*. Washington, D.C.: American Psychological Association, 1957.
- STRUPP, H. H. & LUBORSKY, L. (Eds.) *Research in psychotherapy*. (Proceedings of a Conference, Chapel Hill, N.C., 1961) Vol. 2. Washington, D.C.: American Psychological Association, 1962.
- UNIVERSITY OF THE STATE OF NEW YORK. *Psychology. Laws, rules, information*. (Handbook 51, Professional Education) New York: Author, 1961.

WRIGHT, B. A. (Ed.) *Psychology and rehabilitation*. (The Proceedings of an Institute on the Roles of Psychology and Psychologists in Rehabilitation held at Princeton, N.J., 1958) Washington, D.C.: American Psychological Association, 1959.

YOLLES, S. F. The role of the psychologist in comprehensive mental health centers: The National Institute of Mental Health view. *American Psychologist*, 1966, 21, 37-41.

ZIMET, C. N., & THRONE, F. M. (Eds.) *Preconference materials prepared for the conference on the professional preparation of clinical psychologists*. Washington, D.C.: American Psychological Association, 1965.

Dr. BRAYFIELD. It is our view that the 89th Congress acted wisely, farsightedly—and indeed—and I stress this—courageously—in providing for the coverage of mental health services in the 1965 medicare legislation. It is our hope that we, in turn, are acting responsibly when today we bring to your attention what we believe to be an inadvertent deficiency in the legislation.

We believe that there is a significant practical as well as humanitarian case to be made for enlarging and extending accessibility to mental health services via prepaid health insurance.

Two recent studies conducted at Kaiser-Permanente in San Francisco, one covering a span of 3 years and another covering 6 years, reveal that high medical users significantly reduced their utilization of medical facilities following psychotherapy. Viewed from the overall perspective of total insurance costs, the costs of providing psychotherapy may be more than offset by the savings in general medical costs. The medicare program provides an opportunity to gather the relevant information.

I appreciate the opportunity to appear here today to discuss these matters of mutual concern. I will be happy to clarify my remarks now or at a later time.

Mr. WATTS. Thank you very much for an excellent statement.

Does anybody have any questions?

Mr. BROYHILL. One brief one, Mr. Chairman.

Dr. Brayfield, what is the principal difference between a psychiatrist and a psychologist? I thought this might be well to put in the record at this time.

Dr. BRAYFIELD. Yes.

Mr. BROYHILL. The difference in the educational requirements, the treatment that a psychologist may give that a psychiatrist would not give, and vice versa. I know on the question of drugs that a psychologist cannot administer them. Do you have a brief explanation of the difference.

Dr. BRAYFIELD. Yes, I would be very happy to respond to that.

Mr. BROYHILL. Without bias of course.

Dr. BRAYFIELD. I should say that I have submitted for the hearing record a more extended statement which does go to the question you ask and in both instances they are written by physicians, in the one instance a psychiatrist, so if there is bias I will let that stand for them.

But I would like to respond very briefly. First a psychiatrist comes out of a biological science background and the major differentiation is that by law he is permitted to prescribe drugs. This is the major practical differentiation. The psychologist in contrast comes out of a behavioral science background and he does not prescribe drugs nor does he, as the saying goes, lay on hands.

If you would go into an office building where a psychologist is in practice and a psychiatrist in practice and if you inspected the patients going in the two different doors and if you inspected what the psychiatrist and the psychologist do with those patients you would find almost no differences.

Basically both professions are engaging in diagnosis and basically both professions are offering treatment, most frequently in the form of psychotherapy, a verbal talking procedure, and their activities are indistinguishable.

I think it is a historic accident perhaps that psychiatry did indeed develop out of medicine originally. Many, particularly the younger men, in the field of psychiatry have advocated that there be only a single profession in this field.

Unfortunately, there is resistance to such a suggestion from medical schools and from departments of psychology, understandably, but I think it does indicate that the two professions have come very closely together.

Mr. BROYHILL. Would there be any instances or many instances wherein a psychiatrist would refer a patient to a psychologist?

Dr. BRAYFIELD. Yes. It happens frequently and the referral routings go both ways, sometimes from the psychiatrist to the psychologist, sometimes from the psychologist to the psychiatrist and frequently you may find that they will not necessarily share offices, but have offices in the same building and refer back and forth.

Just as psychiatrists among themselves may refer back and forth, psychologists among themselves refer back and forth because a person may have developed such a specialized practice that he may be particularly expert with children or particularly expert with the elderly, these kinds of differences.

Mr. BROYHILL. Thank you.

Dr. BRAYFIELD. I appreciate your clarifying the question.

Mr. BURKE (presiding). Thank you, Dr. Brayfield. We appreciate your statement very much.

(The following letter was received by the committee:)

AMERICAN PSYCHOLOGICAL ASSOCIATION,
Washington, D.C., April 12, 1967.

Mr. LEO H. IRWIN,
Chief Counsel, House Ways and Means Committee, U.S. House of Representatives, Washington, D.C.

DEAR MR. IRWIN: With respect to amendments to Medicare, our Association, and its affiliated state Psychological Associations, has drafted a bill to include psychologists' services. This bill has been reviewed and approved by our legal counsel, the firm of Arnold and Porter.

I am enclosing six sets of the bill and a memorandum of explanation. We know that you and your staff associates would wish to have copies of this material.

Please feel free to call me at any time if you have questions or desire further clarification.

Sincerely,

JOHN J. McMILLAN,
Administrative Officer, State and Professional Affairs.

MARCH 29, 1967.

Subject: A Bill to Amend Title XVIII of the Social Security Act to Provide Payment for Psychologists' Services Under the Program of Supplemental Medical Insurance Benefits for the Aged.

What It Is and What It Does

Attached is a copy of a proposed bill to amend the Medicare portion of the Social Security Act for psychologists' services under the program of supplemental medical insurance benefits for the aged (Title 18, Part B).

The present statute and regulations require that any services rendered by qualified psychologists (under Part B) are only reimbursable if they are incident to a physician's services or if they consist of diagnostic testing performed on referral from a physician.

The proposed amendment to the law would provide for services of psychologists "whether or not rendered pursuant to a physician's referral or direction". Section 1861 of the Act would be amended to define psychologists' services as "professional services performed by psychologists, including diagnosis, treatment, consultation, and home, office, and institutional calls in connection with mental, psychoneurotic, and personality disorders of an individual, where such services are provided by a psychologist who is certified or licensed to provide such services in the state where the services are provided".

Such an amendment would not extend the range of conditions covered under Part B of the present statute; it would only extend the range of qualified professionals available to provide the same service.

Equities of this Bill

The Present Medicare legislation and regulations impose undesirable constraints on the delivery of mental health services and add unnecessary costs by requiring that the services of psychologists be "incident to a physician's services". The public interest is not served by this requirement. It restricts the patient's direct access to services and adds to the cost. It curtails already limited sources of help. It contradicts earlier Congressional policy as for example, embodied in the Community Mental Health Centers legislation, which stressed optimal utilization of all recognized mental health professionals.

This is a deficiency in the Medicare legislation. The 1967 administration amendments, H.R. 5710, do not rectify this inequity. The attached bill would do so.

For a more detailed presentation of the case supporting the attached amendment, please see the statement presented to the House Ways and Means Committee on March 10, 1967 by Dr. Arthur H. Brayfield, Executive Officer of the American Psychological Association.

For additional information relating to the services of psychologists under voluntary health insurance plans see the enclosed brochure entitled "The Psychologist and Voluntary Health Insurance", a formal position statement of the American Psychological Association.

A BILL To Amend Title XVIII of the Social Security Act to Provide Payment for Psychologists' Services under the Program of Supplemental Medical Insurance Benefits for the Aged

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That:

(a) Section 1861(s) (1) of the Social Security Act is amended by adding before the semicolon and after "services" the following: "or psychologists' services, whether or not rendered pursuant to a physician's referral or direction;"

(b) Section 1861 of such Act is amended by adding at the end thereof the following new subsection:

"PSYCHOLOGISTS' SERVICES

"(z) The term 'psychologists' services' means professional services performed by psychologists, including diagnosis, treatment, consultation, and home, office and institutional calls in connection with mental, psychoneurotic, and personality disorders of an individual, where such services are provided by a psychologist who is certified or licensed to provide such services in the state where the services are provided."

Mr. BURKE. The next witness is Bernard I. Diamond. For the record, Mr. Diamond, would you identify yourself and your association and also your associates?

STATEMENT OF BERNARD I. DIAMOND, CHAIRMAN, GOVERNMENT AND PROFESSIONAL RELATIONS COUNCIL, AMERICAN ASSOCIATION OF BIOANALYSTS, ACCOMPANIED BY ROBERT S. BOURBON, LEGAL COUNSEL; JOHN S. EGAN, AND BERNARD F. KAPLAN

Mr. DIAMOND. I would be pleased. My name is Bernard Diamond. To my right is Mr. Robert Bourbon, our legal counsel, to my immediate left Mr. John Egan, and to the far left Mr. Bernard Kaplan.

Mr. BURKE. And the association you are representing.

Mr. DIAMOND. The American Association of Bioanalysts.

Mr. BURKE. You may proceed.

Mr. DIAMOND. Mr. Chairman and gentlemen of this committee, we appreciate and thank you for this opportunity.

My name is Bernard I. Diamond, director of the Diamond Laboratories, an independent bioanalytical laboratory in Philadelphia, Pa.

I am chairman of the Committee on Governmental and Professional Relations of the American Association of Bioanalysts, which is affiliated with the American Institute of Biological Sciences and the American Association for the Advancement of Science.

I appear before you with counsel, Robert S. Bourbon, Esq., of Silver Spring, Md., and Bernard F. Kaplan and John S. Egan at the request of and representing the following organizations: The American Association of Bioanalysts, the Maryland Association of Bioanalysts, the New York State Association of Clinical Laboratories, the New York State Society of Bioanalysts, the New Jersey Association of Clinical Laboratory Directors, the Oklahoma Association of Bioanalysts, the Pennsylvania Association of Clinical Laboratories, the California Association of Clinical Laboratories, the Rhode Island Association of Clinical Laboratories, the Massachusetts Association of Clinical Laboratories, the Illinois Association of Clinical Laboratories, the Ohio Association of Bioanalysts, the Michigan Association of Bioanalysts, the Connecticut Association of Clinical Laboratories, the Texas Association of Clinical Laboratories, and the Florida Association of Medical Laboratories.

The membership of the American Association of Bioanalysts is composed of individuals who have devoted their talents to the direction and application of the life sciences to clinical laboratory analyses, those who teach such curriculums, and those who hold similar commissions in the armed services or governmental laboratories.

PURPOSE OF PRESENTATION

We do not appear here in opposition to the principles of H.R. 5710, in perfection and expansion of social security program coverage, but rather to present our position concerning and in supplementation of H.R. 5710 as it may affect, or may be made to effect modification of the basic law relating to independent laboratory participation.

It was our privilege to appear before the Senate Finance Committee on May 13, 1965, to testify on behalf of the American Association of Bioanalysts, to urge the inclusion of independent laboratory services in the Social Security Amendments of 1965, introduced by the honorable chairman, Mr. Wilbur Mills, being now Public Law 89-97.

That statement, a copy of which you now have, was commended publicly by the committee chairman. The 1965 statement is offered to support and supplement this statement as an adequate presentation of the arguments for the inclusion of the independent laboratory as a member of the integrated health team.

EXPLANATION OF STATUTORY PROVISIONS RELATING TO INDEPENDENT
LABORATORY REGULATIONS

The Congress saw fit, in title XVIII, subparagraph (B), section 1861(s) of the Medicare Act, to make provision for coverage in the medical insurance program of diagnostic tests performed in independent clinical laboratories—that is, independent of a physician's office and of a participating hospital.

Two conditions are imposed in title XVIII:

1. The independent laboratory must be licensed pursuant to State or local law, or be approved by the State or local agency as meeting the standards established for such licensing or approval, and

2. The independent laboratory must meet the standards found necessary by the Secretary of the Department of Health, Education, and Welfare, to assure the health and safety of individuals with respect to whom tests are to be performed.

The amendment, including the services of independent laboratories, carried the following as an explanation by way of what is now legislative history:

Public health authorities have expressed concern about the effects of payment under the supplementary insurance program for diagnostic tests which are not performed in a hospital or in the attending physician's office. In recent years there has been a rapid growth of so-called "free standing" laboratories specializing in volume testing, and mail order operations. Investigation by state health authorities has produced evidence of unsanitary conditions, errors in tests, faulty records, and subcontracting of work on specimens. Some states have established requirements that these laboratories must meet in order to operate. The proposed change (that is, the amendment) would support state efforts in this direction and would assure that the laboratories meet the same standards essential to the health and safety of beneficiaries as hospital laboratories.

PROMULGATION OF "CONDITIONS FOR COVERAGE OF INDEPENDENT LABORATORIES"

On December 16, 1966, the Department of Health, Education, and Welfare issued regulations, published in the Federal Register, entitled, "Conditions for Coverage of Services of Independent Laboratories." Listed therein are the specific requirements to be met by independent laboratories to qualify their services for reimbursement under medicare.

We submit that the Secretary did not place reliance upon the State authorities in the regulation of independent laboratories and reliance upon the effectiveness of State or State-approved performance evaluation programs as Congress intended. Despite the purpose of the amendment as stated in the explanation, the Secretary has refused to support State efforts under licensure or approval legislation and has chosen instead to impose upon the independent laboratories regulations more stringent by far than those governing hospital or physician-directed laboratories.

APPLICATION OF "CONDITIONS" PAPER QUALIFICATIONS

The conditions imposed by the Secretary upon independent laboratories require an M.D., Ph. D., or M.A. in each of at least four laboratory departments. Only the largest, centrally located laboratories can support such staffing, even assuming that there is an unlimited pool of available M.D.'s, Ph. D.'s, and M. A.'s. The hospital laboratory and the pathologist-directed laboratory are not subject to these staffing requirements. Nor is the laboratory of the physician so subject.

If these regulations remain unchanged, the qualified competent majority of independent laboratories will be unable to continue beyond June 31, 1971. Many will be forced to close their doors long before that time (some by July of this year) despite the "moratorium" provisions which are themselves arbitrary and discriminatory.

"MORATORIUM" UNTIL 1971 AND CONGRESSIONAL INTENT

This "moratorium" affords little or no protection against the arbitrary abuse of administrative authority, even in the interim period before 1971.

We firmly believe that it was not the intent of Congress, when the Medicare Act became law in 1965, to eliminate the independent laboratory from the health team.

A leading representative of the Department of Health, Education, and Welfare is quoted :

Congress itself made certain vital decisions on standards that influenced their level and application, and having defined the upper and lower limits on standards, Congress left most of the remaining decisions to the Secretary of Health, Education and Welfare.

We would hope that Congress would not have given up completely its prerogative in such an important area.

HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

At the same time, as a part of the Medicare Act, Congress established the Health Insurance Benefits Advisory Council to advise the Secretary. At no time was any independent laboratory director or member of the American Association of Bioanalysts invited to attend the deliberations of this important Council. To this moment, the independent laboratory director is not represented on this Council.

ABILITY OF INDEPENDENT LABORATORIES TO MEET "CONDITIONS"

Most of the independent laboratories of the Nation cannot possibly meet the conditions. They are unbalanced in favor of hospital-, pathologist-, and physician-directed laboratories. They are unreasonable and unrealistic and are predicated upon the entirely unsupported assumption that only an M.D., Ph. D. or M.A. will qualify a scientist to direct bioanalytical testing in a clinical laboratory.

Nothing could be further from the fact. Thousands of independent laboratories are now competently serving the public and are directed by clinical chemists, microbiologists, and other recognized scientists

who do not hold such degrees. The services of these scientists even now are being relied upon with justified confidence by thousands of physicians caring for millions of patients each year.

EFFECT OF "CONDITIONS"

The "conditions" promulgated by the Department of Health, Education, and Welfare are in conflict with, we submit, the underlying philosophy and objectives of the medicare program—the marshaling of all available and adequate facilities and services in an integrated program of total health care.

Even if the existing independent laboratories were permitted to qualify during the interim period, it would be impossible for most of them to qualify beyond June 30, 1971. At that time, if not sooner, the public will be deprived of the convenient services of the independent laboratories and their reservoir of trained, experienced, and fully qualified personnel.

These laboratories and their personnel have performed competently for many years under State licensing and performance evaluation programs. They should be permitted to continue to perform in the future, if they perform competently.

We are alarmed and aroused because our repeated protests have elicited little response from the Secretary, because the Secretary's power of reasonable and necessary regulation has been arbitrarily exercised to exclude the independent laboratory regardless of its ability to perform, placing reliance on academic achievement beyond that required and reasonably necessary to achieve competence and efficiency in the performance of bioanalytical testing.

The "conditions" will discourage entry into the field of bioanalysis, creating an increasingly burdensome demand upon the hospital- and pathologist-directed laboratories, and serious difficulties for the physician who needs to care for his senior citizens and others.

There are other ways to find and eliminate the incompetent besides foreclosure of all.

PERFORMANCE AND EVALUATION

We believe the independent laboratory now operating is entitled to a realistic and bona fide evaluation of its ability to perform. We further believe that in keeping with the purpose of the 1965 Medicare Act, as previously stated in the explanation licensing or approval under State law, on-site inspection and satisfactory performance under on-going State evaluation programs do and should qualify the independent laboratory and its personnel for coverage under medicare.

Performance should always be the primary and practical standard for measuring the ability of the laboratory to render quality service.

CURRENT RECOGNITION OF INDEPENDENT LABORATORY SERVICES

The Veterans' Administration, Blue Cross and Blue Shield, the Armed Forces medicare program, many private insurance companies and innumerable health and welfare agencies throughout the Nation have recognized and are now relying upon the testing services of independent laboratories. These "conditions" are damaging to the pub-

lic, depriving them of an available, competent, and convenient health service. Such stringent requirements are not necessary. They will not protect the public against the unscrupulous or incompetent.

CONCERN BY INDEPENDENT LABORATORIES FOR PUBLIC SAFEGUARDS

We join the Secretary of Health, Education, and Welfare in a common desire to improve the work of the clinical laboratory and to safeguard the public against incompetence. We join all members of the health team in our deep concern for the health and safety of the public. Regulation by department heads under legislative authority is permitted under the law in implementation and effectuation of legislative intent and purpose.

We challenge these regulations. We submit that the regulations do not implement and effectuate, but rather conflict with and defeat the legislative intent and purpose implicit in the act—recognition of the independent laboratory as a member of the health team.

RECOMMENDATIONS

We recommend the following:

A. That the Congress, in its consideration of H.R. 5710, reexamine, with particularity, its intent with reference to the continuation of competent, performing independent laboratory services as an integral part of a public-oriented health program, for which the States have primary, or at the least, joint responsibility.

B. Consistent with the declared intent of the administration to assist the States financially to improve their independent laboratory services, that the States be afforded reasonable opportunity to effectuate such improvements.

C. Consideration of amendatory legislation such as the following:

Following "as the Secretary may find necessary" in subparagraph (11) of section 1861(s) of title XVIII, Public Law 89-97, add the following:

Provided, however, that any independent laboratory which is participating or shall hereafter participate in a State or State-approved on-going proficiency testing program and which either is licensed or approved under State or applicable local law or has been in full-time operation for at least two years prior to July 1, 1966, shall be qualified for certification for reimbursement under this Act. The director of such laboratory shall be recognized under this Act as qualified to continue to serve in such capacity.

CONCLUSION

We therefore recommend and request your consideration of the foregoing remarks and suggested amendatory legislation, as they pertain to regulation of independent laboratory services under the medicare program.

Thank you very much.

Mr. BURKE. Thank you. Do any of the other gentlemen have a statement?

Mr. DIAMOND. No, sir.

Mr. BURKE. Would you answer this question, please?

How many States license these independent laboratories?

Mr. DIAMOND. At the present time there are approximately 11 or 12 States which have licensing laws. If you like, I can tell you the names of those States.

Mr. BURKE. Coming from Massachusetts, I am interested in that State.

Mr. DIAMOND. Massachusetts presently has a bill, I believe, in the legislature, and there is some discussion among the various professional groups as to just what the content of the legislation should be. Massachusetts has had a history of attempting to introduce legislation for many years, but I think perhaps, Congressman, you will find out that there has been considerable resistance to such legislation by important members of the professional community in terms of granting recognition to this type of service in the community, so there has been a problem in Massachusetts and in other States also.

Mr. BURKE. I think you must realize the Secretary has a problem here in recognizing what laboratory is competent to do this work. There is one question I raise about your recommendation, excepting an independent laboratory that has been in full-time operation for at least 2 years.

Is it possible that a laboratory could be in operation for 2 years and not be able to fully—

Mr. DIAMOND. I think if you will review this, we insist that the laboratory perform in a program of evaluation of performance. We call this, as a matter of fact, ongoing performance. We are not asking here for a grandfather clause. This is to admit someone in under the law who can prove that he can perform, and the State agency has had this responsibility.

They send out unknown specimens to the laboratories and the laboratories return values that are within acceptable limits.

Now, it is true that there are some States in the country that have not set up these programs yet, but we feel that the funding provided by the Government could help these States to encourage these programs and given a reasonable amount of time, we think that the independent laboratories could qualify on a high level of performance.

Mr. BURKE. Thank you. That is all at this time. Thank you very much.

Mr. DIAMOND. Thank you, Mr. Chairman.

(The following letters were received by the committee:)

AMERICAN ASSOCIATION OF BIOANALYSTS,
Dubuque, Iowa, March 6, 1967.

Hon. WILBUR D. MILLS,
Chairman of House Ways and Means Committee, House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN MILLS: In reference to the revised HEW medicare bill recorded in the Federal Register, vol. 31, No. 243, on December 16, 1966, we, the members of the American Association of Bioanalysts, feel that the necessary changes have not been made.

Our official representative, Mr. Bernard Diamond, will be appearing before you to present the points we wish to have considered and the necessary changes be made. Your valuable and just consideration will be most welcome.

Respectfully yours,

GEORGE M. MARUYAMA, M.S.,
President.

MACOMB CLINICAL LABORATORY,
Mount Clemens, Mich., March 18, 1967.

Representative WILBUR D. MILLS,
Chairman, Ways and Means Committee,
House of Representatives, Washington, D.C.

HON. WILBUR D. MILLS: On March 10th members of the American Association of Bioanalysts testified at a hearing regarding H.R. 5710, a bill of amendments to the social security program.

As a voter of the State of Michigan and as a member of the American Association of Bioanalysts, I heartily support the testimony presented by Bernard Diamond and representatives of the American Association of Bioanalysts. I would urge that the medicare law be amended as recommended by Bernard Diamond in the best interest of the senior citizens of our community as well as those members of the profession who serve these people so well; namely, the independent laboratory owner.

Very sincerely yours,

GILBERT E. ZOOK.

Mr. BURKE. Our next witness is William C. Ellis.
Give us your name and organization, please.

**STATEMENT OF WILLIAM C. ELLIS, COUNSEL, MASSACHUSETTS
SOCIETY OF REGISTERED PHYSICAL THERAPISTS, ACCOMPANIED
BY WALTER HOLDER, PRESIDENT**

Mr. ELLIS. Mr. Chairman and members of the Committee on Ways and Means, my name is William C. Ellis and I am an attorney at law, and my address is 1372 Hancock Street in the city of Quincy, Mass. I am counsel for and represent the Massachusetts Society of Registered Physical Therapists, a society which was chartered and incorporated for the betterment and improvement of the practice of physical therapy on April 26, 1946, over 20 years ago.

With me today is Walter Holder, the president of our society. We seek to amend the law, or at least to change the formulated regulations as such, so that they may come within the definition set forth for a "qualified physical therapist" in the medicare program.

By way of background, may I say that our group originally banded themselves together back in 1944, and practically every physical therapist in Massachusetts was a member. At that time, there were no approved schools of physical therapy, excepting Simmons College, which had a course, and there were no laws regulating the practice of physical therapy and anyone could practice it without the sanction of the State.

Their purpose in grouping together in 1944 was to have a central location where practicing physical therapists could meet, discuss the different changes, latest equipment and advancements in their chosen work so that all could know and be aware of the latest and most complete information available, and also to set up standards and rules so that every member would be a credit to the practice of physical therapy.

And this was their purpose under which they were incorporated under the laws of Massachusetts on April 26, 1946.

All members of the society were carefully screened to prove that he or she was working at physical therapy and had the proper educational background, experience, temperament, and ability to become a member.

On the board of admissions at that time was Jack Fadden, whom I think you will remember as physical therapist and trainer to all Harvard University athletic teams for a number of years, as well as physical therapist and trainer of the Boston Red Sox and the Boston Bruins. Ted Williams was his greatest admirer.

Also Warren J. Bailey, physical therapist and first-aid man to the Boston Consolidated Gas Co. for over 30 years; also Anna T. Curran, a physical therapist in Greater Boston hospitals for over 25 years.

And everyone that was accepted had to have at least 5 years' physical therapy experience.

In 1958 a physical therapy law was enacted in Massachusetts which we like to feel is one of the finest medical centers in the world. This law required that all persons practicing physical therapy be registered with the board of registration in medicine, which supervises all physicians and surgeons in the Commonwealth. The law stipulated that any person who applied for such registration on or before December 31, 1959, who was (1) practicing physical therapy in a competent manner in Massachusetts and was so practicing for 3 years immediately proceeding and (2) was of good moral character—could be registered under the act. All of the members of the society became registered under this law.

This law also provided that physical therapy could only be practiced under the prescription, supervision, and direction of a person licensed in Massachusetts to practice medicine or surgery, M.D.'s. Registrations must be renewed and still have to every 2 years.

These registered physical therapists were independent physical therapists—they were not on the payroll of anyone—they practiced their profession only under the prescription, supervision and direction of a physician or surgeon. And it goes without saying, gentlemen, that if they were not competent in their job—if they were not qualified or if the patients complained—then they would not be in business for any time at all.

And certainly any surgeon or physician would only want the best in physical therapy—a physical therapist who was competent and reliable in every way possible, for surely it all adds up to part of his care and treatment. And our physical therapists have always been kept busy, I have never heard of any complaints of their work.

It all adds up to the fact that their ability came through experience.

And then along came the requirements under the medicare program, and a major part, as you probably know, of physical therapy embraces our older citizens.

Medicare defined a "qualified physical therapist" as a graduate from a physical therapist curriculum approved by the American Physical Therapist Association from 1928 to 1936, that is over 30 years ago, or by the council on medical education and hospitals or by the American Medical Association from 1936 to 1960, or by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association since 1960.

We received a letter from Robert M. Ball, Commissioner of Social Security, dated November 7, 1966, in which he stated the definition of a "qualified physical therapist" as contained in proposed regulations in the medicare program as a "graduate of a program in physical

therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, or its equivalent, and, when applicable, is licensed or registered by the state."

What these programs are, or what the collaboration brought about is not spelled out or explained.

What we do know is that the physical therapists of our society, and registered under the laws of Massachusetts, with their unquestioned experience, ability, competency, and availability at all times are ruled out under this definition. And considering availability, and there is an acute shortage of physical therapists at the present time, the above organizations or their representatives are not limited in the Greater Boston telephone directory—indeed it seems that the only physical therapists that are listed are members of our society.

But Mr. Ball did explain in his letter that they had received a number of comments from individuals and organizations, many of which recommended alternative requirements to those stated in their definition and that they are evaluating them before final publication in the Federal Register.

Consequently, we respectfully submit as an amendment to the definition of "qualified physical therapist" under the medicare program, the following:

"Qualified Physical Therapists"—"a person registered or licensed as a physical therapist under the laws of any State, who has been practicing physical therapy at least 15 years, and who practices only under the prescription, supervision, and direction of a person licensed in said State to practice medicine and surgery."

Along with the foregoing the physical therapist under the medicare program must be on the personnel staff of the physician who retains him; he must be in his employ, and the charges for the physical therapy treatments must be on the physician's own bill.

Just how a physician or surgeon can cope with this, filling out W-2's, taking our social security, Blue Cross and the like, is hard to imagine. Particularly, when one envisions a busy doctor trying to handle his patients day and night.

Concerning home health agencies—the program requires that the "qualified physical therapist" must be on their staff, must be an employee of the agency or have an arrangement or contract with it. But along with that, billing and payment for the physical therapist's treatments must be by the home health agency on the home health billing form. Respectfully, I submit that this procedure would also require the deduction of income tax and social security payments.

We respectfully submit, gentlemen, bills should be itemized and submitted by a registered physical therapist and certified by attending physician or surgeon as proper under penalty of perjury.

Mr. Chairman and members of this committee, I wish to thank you very much for giving me the opportunity of appearing before you today to express my views and those of the physical therapists in the Commonwealth of Massachusetts.

I thank you for your attention.

The CHAIRMAN. Mr. Ellis, we thank you, sir, for coming to us with your statement. We appreciate it very much.

Are there any questions of Mr. Ellis?

Thank you, Mr. Ellis.

Mr. ELLIS. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Stein. Mr. Stein, if you will give us your name, address, and capacity in which you appear we will be glad to recognize you.

**STATEMENT OF ARTHUR STEIN, TREASURER, MASSACHUSETTS
FEDERATION OF NURSING HOMES, ACCOMPANIED BY MRS. RITA
M. WELCH, PRESIDENT; AND LAWRENCE WARNER, CHAIRMAN,
LEGISLATIVE COMMITTEE**

Mr. STEIN. I am Arthur Stein, treasurer of the Massachusetts Federation of Nursing Homes.

The CHAIRMAN. We are glad to have you with us today, sir, and you are recognized.

Mr. STEIN. Mr. Chairman, I would like to mention I have with me, Mrs. Rita M. Welch, who is president of the Massachusetts Federation of Nursing Homes. She is a member of the title XIX commission in Massachusetts, and I have with me too Mr. Lawrence Warner, who is chairman of our legislative committee.

The CHAIRMAN. We appreciate your bringing these people with you and we appreciate having them here. You are recognized, sir.

Mr. STEIN. The Massachusetts Federation of Nursing Homes represents skilled nursing homes and extended care facilities in Massachusetts, representing 22,000 of the 30,000 beds.

My name is Arthur Stein. I am treasurer of the Massachusetts Federation of Nursing Homes. I am administrator of an extended care facility that is also a skilled nursing home. I am a licensed public accountant in Massachusetts, a member of the Advisory Committee, Massachusetts Department of Public Health, Nursing Home Division.

Section 129 of H.R. 5710 requires the funding of depreciation for all providers of service.

If this were enacted into law, it would destroy the nursing home industry of our Nation because 85 percent of the country's nursing homes are proprietary, and they would be unable to pay the principal on their mortgages.

Our Nation's banking and insurance institutions would suffer irreparable losses and a rash of foreclosures would ensue. The concept of funding depreciation under medicare was first considered by the Senate Finance Committee in its hearings on the "Principles of reimbursement" on May 25, 1966; but this was in reference to assets of providers financed with Federal or public funds and properly so.

Under existing regulations, providers with assets financed by Federal or public funds are allowed to depreciate the same but are not required to fund the money received. They are, therefore, permitted to use the payments for depreciation in any manner they choose.

Persons borrowing money from banks and insurance companies, on the other hand, to acquire capital assets, must repay the loan. These principal payments are not costs, and therefore, come from depreciation and whatever modest capital return that is allowed.

It is, therefore, only right that depreciation payments for assets financed with public funds be funded, but the concept should not be extended as to destroy the free standing nursing homes and abolish free enterprise in the field of health care. Such a disastrous result would deprive our senior citizens of quality beds needed for their case.

The attached amendment to the bill would remedy this situation, and accomplish the necessary result.

(The amendment is as follows:)

DEPRECIATION ALLOWANCE FOR PURPOSE OF DETERMINING COST

SUBSTITUTE (PAGE 57 OF BILL, LINES 21-24)

Section 129(a) (1) . . .

"(5) (A) Notwithstanding any other provision of this title, the term "reasonable cost" shall include amounts attributable to depreciation of plant and equipment; and in the case of a provider of service with assets financed with Federal or public funds, as to said assets, only with respect to periods; etc. . . ."

Mr. STEIN. Regarding the title XIX standards, the Massachusetts Commissioner of Public Welfare agrees with the position of the Massachusetts Federation of Nursing Homes that skilled nursing homes are institutions differing from extended care facilities and that the great need for beds exists in the skilled nursing home.

To impose the standards of title XVIII on title XIX as is the present policy of HEW not only violates the act passed by Congress and the intent and purpose of Congress, but also fails to take into account the realities of the health-care needs of our aged, and works to deprive them of sufficient quality facilities for their care.

There is no reason why separate standards for skilled nursing homes cannot be set up by the States as Congress intended and insure an adequate supply of beds for our elderly.

I would like to mention also that Massachusetts has 17,000 licensed practical nurses, of which 11,000 are by waiver and at the present time there are 8,000 currently employed. I would like at this time to thank the chairman and members of this committee for hearing us.

Mr. BURKE (presiding). Thank you. Does either one of your associates wish to make any statement?

Mr. STEIN. No.

Mr. BURKE. There being no further questions the committee thanks you for your appearance and for the information you have given the committee.

Mr. STEIN. Thank you, Mr. Chairman.

Mr. BURKE. Thank you very much. There being no further witnesses, without objection the committee stands adjourned until Monday next at 10 a.m.

(Whereupon, at 12:36 p.m., the committee adjourned to reconvene at 10 a.m. Monday, March 13, 1967.)

PRESIDENT'S PROPOSALS FOR REVISION IN THE SOCIAL SECURITY SYSTEM

MONDAY, MARCH 13, 1967

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met at 10 a.m., pursuant to recess, in the committee room, Longworth House Office Building, Hon. Wilbur D. Mills (chairman of the committee) presiding.

The CHAIRMAN. The committee will please be in order.

We have with us today the Honorable Charles S. Gubser from the State of California. We are pleased that you could take the time to come before us today. You may proceed.

STATEMENT OF HON. CHARLES S. GUBSER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. GUBSER. Mr. Chairman and members of the committee, I appreciate this opportunity to testify before your committee in behalf of my bill, H.R. 660, which would restore the right of persons over 65 to deduct all medical care expenses when calculating income taxes.

You will remember that, when Congress passed the medicare program, it provided that for income-tax purposes, medical costs could only be deducted in an amount which exceeded 3 percent of adjusted gross income. Previously those over 65 years of age had the privilege of deducting all such expenses.

This is unfair and a retrogression from well-established benefits which have been accorded our older citizens.

The theory behind the congressional action in passing the Social Security Amendments of 1965 was that, with medicare, a heavy financial burden for older people would be relieved and the reasons for the special medical care expense provisions in the tax law would no longer be present.

Mr. Chairman, this conclusion is not necessarily valid. There are thousands of senior citizens who are not covered by medicare. Yet the 3-percent rule deprives them of a right they previously enjoyed.

Furthermore, with the continued shortage of hospital beds, trained doctors, nurses, and other medical personnel, it is not at all certain that we can provide the medical care which the 1965 law promised. Though it certainly was not and is not the intention of any agency of this Government to renege on a promise, the fact still remains that this promise, which was given in exchange for increased tax liability to senior citizens, may not be completely fulfilled.

In the committee report which accompanied the Social Security Amendments of 1965, it was frankly stated that depriving senior citizens of their additional medical care expense deductions would "provide an increase in revenue." Mr. Chairman, I do not believe that most Members of Congress intended that the medicare benefits should be paid for by an increase in tax liability for medical expenses.

This new feature hits only those with enough retired income to have acquired a tax liability. This means that once again the tax laws discriminate against the man who has worked and saved for his old age.

I believe strongly that, when a person reaches 65, he has a right to be considered in a different tax category. First of all, his earning capacity has stopped or materially lessened. Secondly, what he has saved through the fruits of his lifetime of labor has been partially denied him by inflation caused by past and current government spending. Thirdly, it goes without saying that his susceptibility to illness and his need for medical care are vastly increased.

Mr. Chairman, when Congress passed the Social Security Amendments of 1965, amendments were not allowed and it was necessary to vote for or against the bill, on balance. Had the membership been given the opportunity to vote on an amendment to delete the provision which limited the deduction of medical expenses, such an amendment certainly would have prevailed. My bill will correct this inequity and, I sincerely believe, truly reflect the will of Congress.

The CHAIRMAN. Are there any questions? If not, we wish to thank you for your statement.

Our next witness this morning is Dr. Ostrander of the American Dental Association. If you will please identify yourself for our record by giving us your name, your address, and capacity in which you appear, we will be glad to recognize you, sir.

**STATEMENT OF DR. F. DARL OSTRANDER, PRESIDENT-ELECT,
AMERICAN DENTAL ASSOCIATION, ACCOMPANIED BY BERNARD
J. CONWAY, CHIEF LEGAL OFFICER**

Dr. OSTRANDER. Mr. Chairman, members of the committee, my name is Dr. F. Darl Ostrander from Ann Arbor, Mich. I am president-elect of the American Dental Association.

With me today on my right is Mr. Bernard J. Conway, chief legal officer of the association.

We are grateful, Mr. Chairman, for this opportunity to appear before you to discuss section 302 of title III of H.R. 5710 which proposes amending part 4, title V of the Social Security Act.

This new section would authorize special project grants for the dental health of children. These would be awarded to State or local health agencies or to other public or nonprofit private agencies, institutions, or organizations.

The bill would establish a 5-year program beginning with an authorization of \$4 million for fiscal 1968. Federal participation would be limited to 75 percent of the cost of such projects. The administration has indicated that about 10 pilot projects, providing care for approximately 100,000 needy school and preschool children, would be initiated during the first year.

The American Dental Association supports the intent and principle of this proposal and urges favorable consideration of it by this committee.

DENTAL DISEASE STATISTICS

The scope of dental disease, as it exists today, qualifies it as one of the most frustrating of all the ills that plague us. Its most common manifestations are tooth decay and gum disease. There is almost literally no one in the country who is not suffering from one or the other.

And yet, there are few diseases that are as readily controllable and preventable as are these two. The gap between what can be accomplished and what is being accomplished is enormous.

Secretary Gardner, in the testimony that opened these hearings, recited to you some of the deplorable statistics: "By age 5, a child has an average of three carious teeth. By age 15, the average youth has 11 permanent teeth damaged or destroyed."

The impact of this neglect is that, in later years, a vast percentage of Americans have suffered the loss of many or all of their natural teeth.

Such dental disorders exact a heavy price. Recruits to the Armed Forces need extensive dental care, costing an average of \$63 per recruit, before they are fully fit for duty. It is estimated that in industry there is an annual loss of 85 million man-hours, valued at \$250 million, because of dental diseases. And these dollar figures cannot, of course, take into account the pain that is suffered or the permanent disability with regard to oral health that often eventuates. Nor do they reflect the dollar difference between what it costs to rehabilitate a long-neglected mouth compared with the more modest amount that would need to be spent for routine preventive care.

FREQUENCY OF CARE FOR NEEDY

It should be noted with regard to this last point that there is a discernible relationship between income and the frequency with which dental services are sought. Nearly 70 percent of the children whose families earn less than \$4,000 annually do not receive dental services. For children from families whose income exceeds \$10,000, the statistics are more than reversed, with 80 percent seeing a dentist on a reasonably regular basis.

The dental profession's longstanding concern over this problem is centered about children. The reason for this is that it is neither feasible nor professionally desirable to control the dental disease problem in this country solely by providing restorative treatment to the whole population.

If, however, we can once manage to bring a generation of children to a state of sound oral health, it will then be a relatively simple matter to maintain that condition as the child grows up and lives out his span of years.

PUBLIC SECTOR-PRIVATE SECTOR COOPERATION

The profession recognized long ago that achievement of this goal required close cooperation between the private and public sectors of the Nation.

It is the private sector, first, that encompasses nearly all the professional manpower available to the Nation. The vast majority of dentists actually engaged in chairside care—as opposed to those carrying out administrative, educational, or research functions—provide that care within the private practice system.

Further, the vast majority of families are perfectly capable of maintaining, as they do at present, personal responsibility for their dental health care. Neither the profession nor the administration, as we understand the proposal, is suggesting Federal support of dental care for children whose families are well able to afford it.

The association does believe, however, that an income tax credit for the amount spent annually by a family in securing dental services for children would provide a useful and justifiable incentive for regular care. The association, further, has long advocated complete deductibility of the cost of health and medical services.

Finally, the private sector's importance derives from the rapid and wholly welcome development of prepayment mechanisms that has occurred in the past few years. For the most part, this has taken the form of group dental care coverage for employees and their dependents. A number of private insurance companies are now engaged in underwriting such contracts.

In addition, the profession has encouraged the State-level development of dental service corporations, a nonprofit, prepayment organization, similar to Blue Shield, that contracts with groups for the provision of dental-care benefits in the offices of private dentists. At present, 28 States have chartered dental service corporations.

While the total number of people now covered by one form or other of dental prepayment is not large, there is enough evidence already available to document the viability of the idea and to indicate a rapid growth in its acceptance in the years immediately ahead. One reason we favor the proposal before you is our belief that it will give further impetus to this private sector activity in the area of prepayment.

The public sector's involvement in the total program of dental care for children is twofold. There are, first of all, those activities that cannot realistically be carried out on an individual basis. Dental health education within the school system would be one example of this sort of activity.

A second would be fluoridation of communal water supplies. This safe, inexpensive, and highly effective public health measure has been of inestimable benefit to thousands of communities across the Nation, reducing the incidence of tooth decay among children by as much as 60 percent, an effect, of course, that benefits the child throughout his life.

And, then, public sector cooperation is required for those children whose families are needy or medically needy. There can be no question but that we are today in a time when it is clearer than ever before that the opportunity to obtain health care is regarded as a right and that our society is pledged to the development of mechanisms effectively assuring that all Americans share fully in this right.

The "medically needy" concept, probably first impressed upon the public consciousness by the Kerr-Mills law, which the chairman of this committee was so instrumental in devising, has proven a highly

useful tool in the Nation's effort to improve the accessibility of health care services.

EFFORTS BY THE PROFESSION

Through the years, in its efforts to meet the challenge of dental health care for all children, the association has been consistent in its espousal of private sector-public sector cooperation.

While constantly searching for ways to better organize the delivery of health services within the private sector, the association has made frequent representations to Congress, and the executive branch, concerning Federal activities in this area that the association felt would be appropriate.

When title XIX legislation was first being considered, for example, the association strongly urged that dental care for children be named one of the mandatory services offered by the States under that program.

The long history of association activity climaxed last year in the adoption by its house of delegates of a dental care program for children that spells out in detail what the association believes should be done. A copy of the program has been made available to every member of the committee, attached to our statement, and it is our hope that each member will have an opportunity to review it.

In broad terms, the program envisions a step-by-step progression toward the final goal of making fully adequate dental services available to all children.

It takes note of a number of reasons why intermediate stages are essential. Paramount among them, perhaps, is the fact that there are still a good many things we need to know before we can be sure which approach, or combination of approaches, is preferable.

And then, an attempt to inaugurate an elaborate program overnight would place a strain on existing resources, particularly with regard to professional manpower, that might prove disruptive.

It is pointed out in the association's program that a soundly based plan would not consist merely in providing chairside care. Equally essential are such elements as dental health education, intensification of our present efforts in pure and applied research, and widespread use of the known principles of preventive treatment.

The profession is firm in its belief that it would be the sheerest folly to attempt a program based on just one of these elements. All are necessary.

The program envisions that a major share of the planning would be done on the local and State level. Though there is no section of the country that does not have a serious dental disease problem, the components of the problem obviously vary somewhat from place to place because of economic, geographic, or population variants.

Prime responsibility for planning public sector participation should be lodged with the State and local departments of health, since, in each locale, it is this agency that has the necessary expertise to judge health needs.

On the national level, the program assumes that responsibility for administration of the public sector would be vested in the Secretary of Health, Education, and Welfare and discharged by dental health

oriented personnel. On all levels, of course, there would need to be the closest cooperation between such other appropriate agencies as those concerned with welfare and education.

Finally, the program notes that the great bulk of activity would remain where it is today, in the private sector. Some \$3 billion a year is being spent presently within the private sector for dental care services. Public funds would never represent more than a very small fraction of this total. In our effort to extend comprehensive care to all children, we should not lose sight of the fact that most children have those services already available and if they do not avail themselves of it, it is for reasons other than economic ones.

IMPLEMENTATION

The first step in implementation of the American Dental Association's dental health program for children would be the establishment of a series of pilot or exploratory programs designed to provide the actuarial and operational experience necessary. The projects would be as diversified as possible, with regard to the complexion of the communities chosen, so that the information elicited would be valid when applied nationally.

The legislation before you provides for such pilot projects. In the first year, they would be 10 in number, would be located in areas of acute poverty and would encompass some 100,000 children.

The association is, of course, pleased at this indication that the administration's thinking seems to be developing along the same line as that already elaborated by the profession.

We would, candidly, have been happier to see a somewhat larger number of projects initiated in the first year. A larger number of projects would make it more certain, to our mind, that we will be able to elicit all of the necessary information in a reasonably brief period of time and then move ahead in an orderly, knowledgeable way.

We do recognize, however, that Congress and the administration must balance needs in a great many areas and then allocate resources as fairly as possible. The important point, the essential point, is that a beginning be made.

The association believes, further, that the first-year funds authorized by the proposal before you are sufficient to support the 10 projects envisaged.

The ultimate success of the initial program and its value to our future progress will, of course, depend to a great extent on the quality of its administration. The association believes it is reasonable to expect that the Secretary will assign prime administrative responsibility to an agency having adequate dental expertise and personnel. We also believe the Secretary should seek the advice of nongovernmental experts through the appointment of an appropriate advisory body.

SUMMARY

In summary, Mr. Chairman, may I express the association's conviction that the problem to which this proposal is directed is a real and pressing one. Indeed, we know of no one concerned with the

Nation's health who does not agree that something must be done soon about the appalling rate of dental disease, especially among needy children. There will never be a more appropriate time to begin than today, when we can take advantage of the considerable impetus already developed within the profession, other private sector organizations, and on all levels of government.

One of the most comforting aspects of the situation is that the solution to a major part of the problem is all but within our grasp. As I said at the beginning of this statement, the gap between what we know can be accomplished and what is in fact being accomplished is enormous.

It is not a matter, as it is so often when dealing with national problems, of applying a solution that one hopes will work or that one thinks might work. We already possess most of the basic knowledge and tools. We are in a position to move ahead rapidly.

What we need to do is to make a start in terms of organization and administration to assure that that knowledge and those tools are applied as efficiently and effectively as possible.

The suggested amendment to part 4, title V of the Social Security Act would enable us to make a prudent beginning. On behalf of the American Dental Association, then, may I urge this committee to give favorable consideration to section 302, title III of H.R. 5710.

This concludes our testimony, Mr. Chairman. On behalf of the association, may I again thank the committee for this opportunity to present our views. We would be glad now to try to answer any questions you and members of the committee may have.

The CHAIRMAN. Dr. Ostrander, we appreciate your statement representing the views of the American Dental Association.

Any questions of Dr. Ostrander? Mr. Curtis.

Mr. CURTIS. Doctor, I am very pleased with this testimony, but I think we need a great deal more information about what is going on in the private sector. You give us generalities. On page 5, you say:

A number of private insurance companies are now engaged in underwriting such contracts.

You point out on page 8:

Some \$3 billion a year is being spent presently within the private sector for dental care services.

And elsewhere you note throughout here that there is considerable activity going on in the private sector.

Now, when the Secretary of Health, Education, and Welfare, Mr. Gardner, testified, one of the criticisms I directed against his paper was that it had solely to do with what the Federal Government might be doing and had no reference at all to what is going on in the private sector, and while the Secretary wasn't here personally at the time, Mr. Cohen was here. I asked if the Department would present to this committee what data they had of what was going on in the private sector.

Maybe there haven't been studies. Let me ask that question. Do you know of any studies that have been made of what actually is going on in the private sector in respect to financing dental care treat-

ment such as insurance programs, as well as group programs, et cetera?

Dr. OSTRANDER. Well, yes, we have information on that. For example, we can say that roughly three million people in the United States presently as covered by prepaid care plans through dental service corporations or insurance programs.

Mr. CURTIS. May I interrupt to ask, does that relate to essentially children, or would that be children and adults?

Dr. OSTRANDER. This includes both children and adults.

Mr. CURTIS. It still would be valuable to know about that. I have been particularly interested in children, and your paper directs attention to them on these prepaid programs. I know some of the labor unions, in fact, one in my own area, the Teamsters, developed a prepaid insurance program for the children of their people. This is, I thought, very important. I think it took them up to age 10 or maybe 12.

Am I not correct in assuming that if you can catch them up to about age 10 or 12 you have really got the bulk of the thing in hand?

Dr. OSTRANDER. Yes. That is our main point in emphasizing the desirability of starting with the younger child, the 6-year-old child, for example. If you can start with this group of children and keep them cared for, the cost for continuing care will be markedly reduced and the problem of dental cripples in the older age group will be largely solved.

Mr. CURTIS. I wonder if I may ask you to supply for the record, if you can, what the situation is in respect to dental insurance programs for children that are coming about. It may be the profit private sector, or it may include work of private nonprofit organizations. It might include work that is being done by local governmental units such as school districts and so forth. I have never seen or had the data presented as to what is going on now, what the rate of progress in this area might be. Can you help us at all?

Dr. OSTRANDER. Mr. Conway, do you have some information on that?

Mr. CONWAY. We will supply that for the record to the best of our ability, Congressman Curtis.

Dr. OSTRANDER. I am sure the information is largely available. It is just a matter of getting it together and getting it to you.

(The following information was received by the committee:)

REPORT ON DENTAL PREPAYMENT PLANS IN THE UNITED STATES

This report is submitted in three parts. Part I is a compilation of two independent reports made respectively by the National Association of Dental Service Plans and by the Subcommittee on Dental Care of the Allied Health Services Committee on the Health Insurance Council. Part II consists of excerpts from the HIC report and Part III is the NADSP report in its entirety.

PART I. FACT SHEET ON DENTAL PREPAYMENT

Growth of prepaid dental plans

As of December 1966, approximately 4 million Americans have prepaid dental care coverage. Dental service corporations showed the greatest growth in coverage, though it is probable that in the case of both dental service corporations and commercial insurance companies, an improvement in reporting methods is partly accountable for the sharp rise between 1965 and 1966.

Administrative mechanism	Number of eligible persons			
	1960	1964	1965	1966
Total.....	732,300	1,469,800	1,988,000	4,092,960
Dental Service Corp.....	9,000	325,300	458,100	1,289,154
Commercial Insurance Co.....	17,500	274,800	550,600	1,601,878
Group practice/clinic.....	535,600	608,100	616,400	765,900
5 other mechanisms.....	170,200	261,600	362,900	437,000

Since 1960, the number of persons eligible for prepaid dental care has increased fivefold. The number of plans has shown comparable growth.

Status of prepaid dental care in 1966

Administrative mechanism	Number of organizations	Number of group plans	Number of eligible persons
Total.....	169	632	4,092,960
Dental Service Corp.....	16	276	1,289,154
Commercial Insurance Co.....	34	424	1,601,878
Group practice/clinic.....	78	95	766,000
Self-insured trust.....	25	25	176,000
Nonprofit Insurance Corp.....	1	191	170,000
Mutual Benefit Association.....	20	20	35,000
Health Service Corp.....	5	8	16,000
Other.....	3	3	40,000

PART II. THE EXTENT OF DENTAL INSURANCE COVERAGE WRITTEN IN THE UNITED STATES BY INSURANCE COMPANIES AS OF JULY 1, 1966 ¹

TABLE Ia.—Group dental insurance coverage in the United States by 34 insurance companies, July 1, 1966

	Total	Schedule plans ¹	Comprehensive plans ²	Combination plans ³
1. Number of master policies.....	424	150	227	47
2. Number of covered persons.....	1,601,878	1,155,304	317,512	129,062
(a) Employees.....	585,337	414,897	121,359	49,081
(b) Dependents.....	1,016,541	740,407	196,153	79,981
3. Dental insurance annualized premium volume (as of July 1, 1966) ⁴	\$44,879,623	\$35,538,727	\$5,894,341	\$3,446,555
4. Dental insurance benefits paid (for the 12-month period ending June 30, 1966) ⁵	\$31,405,694	\$25,006,479	\$2,850,190	\$3,549,025

¹ Plans providing for dollar limits on dental expenses for each procedure performed and with eligible expenses so determined reimbursed at 100 percent or on some percentage basis without a deductible.

² Plans providing for percentage reimbursement (coinsurance) on covered expenses after an initial deductible on some or all types of dental expenses and with no (or but few) dollar limits on covered expenses for individual dental procedures.

³ Plans containing schedule dollar limits on amount of dental expense to be covered as well as a deductible on some or all types of dental expenses and with eligible expenses reimbursed at 100 percent or some other rate of reimbursement.

⁴ Total annual premium for number of insured employees and dependents as of July 1, 1966.

⁵ Since many plans were in force for a period of less than 1 year, the amount of benefit payments should not be related to the premium volume.

It is important to recognize that this total should not be related to the total premium. One reason for this is that the latter was reported on an annualized basis and in a number of instances a plan had been in force for less than 1 year.

¹ It should be noted that it is not possible for the American Dental Association to say that all of the plans listed by the commercial insurance industry are as comprehensive with regard to the services offered as the dental profession considers professionally desirable. With regard to plans offered by dental service corporations, however, it is possible to say that all the plans are comprehensive to the desirable degree.

TABLE Ib.—*Percentage distribution of group dental insurance coverage in the United States by 34 insurance companies by type of plan, July 1, 1966*

[In percent]

	Total	Percent of total		
		Schedule plans ¹	Comprehensive plans ²	Combination plans ³
1. Master policies.....	100	35.4	53.5	11.1
2. Covered persons.....	100	72.1	19.8	8.1
(a) Employees.....	100	70.9	20.7	8.4
(b) Dependents.....	100	72.8	19.3	7.9
3. Dental insurance annualized premium volume (as of July 1, 1966) ⁴	100	79.2	13.1	7.7
4. Dental insurance benefits paid (for the 12-month period ending June 30, 1966).....	100	79.6	9.1	11.3

¹ Plans providing for dollar limits on dental expenses for each procedure performed and with eligible expenses so determined reimbursed at 100 percent or on some percentage basis without a deductible.

² Plans providing for percentage reimbursement (coinsurance) on covered expenses after an initial deductible on some or all types of dental expenses and with no (or but few) dollar limits on covered expenses for individual dental procedures.

³ Plans containing schedule dollar limits on amount of dental expense to be covered as well as a deductible on some or all types of dental expenses and with eligible expenses reimbursed at 100 percent or some other rate of reimbursement.

⁴ Total annual premium for number of insured employees and dependents as of July 1, 1966.

TABLE 2.—*Number of persons covered under group dental insurance plans by 34 insurance companies, by State, July 1, 1966*

State	Total number covered	State	Total number covered
1. Alabama	8,546	27. Montana	2,874
2. Alaska	9,197	28. Nebraska	6,799
3. Arizona	4,399	29. Nevada	960
4. Arkansas	7,910	30. New Hampshire.....	9
5. California	310,249	31. New Jersey.....	15,938
6. Colorado	9,587	32. New Mexico.....	3,223
7. Connecticut	45,336	33. New York.....	277,454
8. Delaware	24	34. North Carolina.....	25,822
9. District of Columbia.....	12,734	35. North Dakota.....	2,156
10. Florida	18,862	36. Ohio	91,944
11. Georgia	18,369	37. Oklahoma	14,425
12. Hawaii	3,405	38. Oregon	61,456
13. Idaho	3,995	39. Pennsylvania	84,279
14. Illinois	50,159	40. Rhode Island.....	206
15. Indiana	51,982	41. South Carolina.....	6,169
16. Iowa	24,554	42. South Dakota.....	1,250
17. Kansas	11,923	43. Tennessee	28,173
18. Kentucky	19,581	44. Texas	76,907
19. Louisiana	13,400	45. Utah	3,522
20. Maine	336	46. Vermont	—
21. Maryland	23,888	47. Virginia	5,424
22. Massachusetts	11,973	48. Washington	49,563
23. Michigan	73,086	49. West Virginia.....	756
24. Minnesota	16,780	50. Wisconsin	26,394
25. Mississippi	4,556	51. Wyoming	1,111
26. Missouri	59,376		

TABLE 3.—Dental insurance coverage in the United States by insurance companies, Dec. 31, 1963, and July 1, 1966

	July 1, 1966	Dec 31, 1963	Increase, 1963-66	
			Number	Percent
Group business:				
1. Number of companies offering dental coverage.....	36	26	10	38
2. Number of companies with policies in force.....	34	16	18	113
3. Number of master policies in force.....	424	66	358	542
4. Number of persons covered.....	1,601,878	334,860	1,267,018	378
(a) Schedule plans.....	1,155,304	237,858	917,446	386
(b) Comprehensive plans.....	317,512	86,495	231,017	267
(c) Combination plans.....	129,062	10,507	118,555	1,128
5. Dental premium volume ¹	\$44,879,623	\$4,332,197		
6. Dental benefits paid.....	\$31,405,694	(²)		
Individual business:				
1. Number of companies offering dental coverage.....	3	1	2	
2. Number of companies with policies in force.....	1	1		

¹ Data on premiums are not comparable between the 2 periods. The figure for 1966 is the annualized volume while for 1963 it represents the amount written during that year only.

² Not available.

PART III. DENTAL SERVICE CORPORATION COVERAGE, AS OF JANUARY 31, 1967

Summary

At the close of business January 31, 1967, the 16 active corporations had 205 private group contracts in force, covering 1,053,755 subscribers. Of these, 192 contracts, covering 1,038,819 persons, were underwritten, and 13 contracts, covering 14,936, were administered on a cost-plus basis. In addition, 71 administrative contracts involving publicly funded programs were in effect covering 235,399 eligible beneficiaries. The combination of contracts in the private and public sector, therefore, totaled 276, with 1,289,154 persons affected, exclusive of dependents.

Public programs, by category

Type of program	Number of programs	Number of beneficiaries
Headstart.....	58	38,861
Community action.....	6	4,842
Job Corps.....	1	128
MAA (Kerr-Mills).....	1	70,000
Public assistance (State).....	1	118,718
Public assistance (county).....	1	750
Maternal and infant care.....	2	1,100
Office of Education, title I.....	1	1,000
Total.....	71	235,399

MONTHLY COVERAGE REPORT SUMMARY—DETAIL BY INDIVIDUAL PLAN

Alabama Dental Care Inc.:

Public: 1 Head Start contract, covering 1,000 children.

California Dental Service:

Private: 135 underwritten contracts, covering 889,688 subscribers.

Public: 13 Head Start contracts, covering 25,000 children; 1 Maternal and Infant Care Program contract, covering 500 mothers.

Colorado Dental Service:

Public: 23 Head Start contracts covering 9,000 children; 1 County Public Assistance contract covering 750 aged adults and children.

Connecticut Dental Service:

Private: 3 underwritten contracts, covering 69 subscribers.

Public: 2 Head Start contracts covering 286 children.

Hawaii Dental Service :

Private: 17 underwritten contracts covering 62,154 subscribers; 3 administrative contracts covering 2,096 persons.

Kentucky Dental Service :

Public: 1 Maternal and Infant Care Program contract covering 600 mothers.

Maine Dental Service Corp. :

Private: 1 administrative contract covering 1,200 persons.

Michigan Dental Service Corp. :

Private: 3 administrative contracts covering 1,650 persons.

Public: 1 MAA contract covering 70,000 aged; 2 Community Action Program contracts covering 842 beneficiaries.

New Hampshire Dental Service Corp. :

Private: 1 administrative contract covering 1,200 persons.

New York Dental Service Corp. :

Private: 4 underwritten contracts covering 438 subscribers.

Ohio State Dental Care Corp. :

Private: 5 underwritten contracts covering 275 subscribers; 1 administrative contract covering 440 persons.

Public: 10 Head Start contracts covering 3,175 children; 4 community Action Program contracts covering 4,000 beneficiaries; 1 Office of Education (Title I) contract covering 1,000 children.

Oregon Dental Service :

Private: 1 underwritten contract covering 750 subscribers; 1 administrative contract covering 2,299 persons.

Public: 1 Head Start contract covering 400 children.

Rhode Island Dental Service Corp. :

Private: 1 administrative contract covering 5,000 persons.

Vermont Dental Service Administrative Corp. :

Private: 1 administrative contract covering 1,000 persons.

Public: 1 Job Corps contract covering 128 persons.

Washington Dental Service :

Private: 26 underwritten contracts covering 85,322 subscribers.

Public: 8 Head Start contracts covering an unknown number of eligibles; 1 State Public Assistance contract covering 118,718 beneficiaries.

Wisconsin Dental Service Corp. :

Private: 1 underwritten contract covering 123 subscribers.

Public: 1 administrative contract covering 51 persons.

The CHAIRMAN. Mr. Schneebeli.

Mr. SCHNEEBELI. Following Mr. Curtis' question, could you give us an approximation of what percentage of schoolchildren are now being cared for in this area by the local school boards? I know in Pennsylvania a lot of the local school boards take care of children and dental work.

Would you have any approximation what percentage of children across the country are being taken care of?

Mr. CONWAY. I am sorry again I can't be too specific across the country, but it is our understanding that most of the programs in the school districts are on an emergency basis. They take care of emergency needs of the children.

Mr. SCHNEEBELI. They are not comprehensive?

Mr. CONWAY. They are not comprehensive.

Mr. SCHNEEBELI. Dr. Ostrander, you said the final goal is to make fully adequate dental services available to all children.

Now, this is a very laudatory goal, we agree with you. What percentage of this objective do you think is the responsibility of the Federal Government?

Dr. OSTRANDER. Well, I would hope that a relatively small percentage of it would be the responsibility of the Federal Government.

Mr. SCHNEEBELI. How do you visualize the Federal Government getting into this thing? What is your concept of the Federal Government's role in this responsibility?

Dr. OSTRANDER. I think our concept is that the Federal Government's role would be restricted to those who are indigent or medically indigent, that the children who are in families who are economically capable of paying for their own dental care should not be supported by the Federal Government.

We have no intent at all of the Federal Government supporting those who are capable.

Mr. SCHNEEBELI. Would you have any idea of the cost of the Federal Government implementing this to take care of the medically indigent?

Mr. CONWAY. The welfare administration has estimated that there may be today some 10 million children, and I am not sure of the age group, but I think this probably goes up to about age 18, who could conceivably be covered by title XIX with its provision for the medically indigent.

Mr. SCHNEEBELI. And the Federal Government would be responsible in this area and how much do you think this would cost?

Mr. CONWAY. Well, again, this is an estimate, but I believe it is probably the best we can give. The Public Health Service and the American Dental Association have in a sense agreed that the cost of taking care of children particularly should come to about \$35 to \$40 per person. This assumes some nonutilization factor and all the other factors that would be considered.

Mr. SCHNEEBELI. It would cost about \$350 to \$400 million a year then?

Mr. CONWAY. That would be true if the program were extended to all of the children that the welfare administration has indicated could be considered medically indigent or indigent.

Mr. SCHNEEBELI. That is about \$400 million a year then this program would cost the Federal Government if implemented in the manner that you recommended.

Mr. CONWAY. Well, our recommendation is that the program be conducted for at least 5 years on a pilot project basis.

Mr. SCHNEEBELI. But I think that you recognize our responsibility would eventually be the ultimate program.

Mr. CONWAY. Yes. May I add one thing? Title XIX already contemplates expansion to dental services. It is built into the legislation and somewhere along the line I believe the dates are set there. I think it is July 1, 1975, when all States with title XIX programs are supposed to have comprehensive health care. This must include a strong element of dental services so I think to the extent that there is a comprehensive treatment program in view, title XIX would probably be that program.

Mr. SCHNEEBELI. But I think you agree that once you start down this road you want to know what the end is going to be and as I can see what you say it would cost probably \$400 million a year on the present basis of cost and population.

Mr. CONWAY. That would be an accurate expression.

Mr. CURTIS. Would you yield?

Mr. SCHNEEBELI. Yes.

Mr. CURTIS. I wondered if some of that cost would be catching up and whether you would then visualize the cost from then on as being that high.

Mr. CONWAY. This is a very good point, Congressman. I am sorry I didn't bring it out. We would expect, providing for age group by age group progressively, that the maintenance cost would be minimal along the line and there would be a severe reduction in cost.

The CHAIRMAN. Mr. Burke.

Mr. BURKE. Doctor, could your association produce the figures on the percentage of men who have been turned down for the draft because of poor teeth.

Dr. OSTRANDER. The Selective Service System does not turn down prospective inductees for their dental health conditions. They are rehabilitated and, as pointed out in our testimony, the average cost for rehabilitating an inductee is approximately \$65 per inductee.

Mr. BURKE. In other words, it would save \$20 a person if we took care of them while young.

Dr. OSTRANDER. It would save much more.

The CHAIRMAN. Any further questions?

If not, Dr. Ostrander and Mr. Conway, we appreciate you both being before the committee this morning.

Dr. OSTRANDER. Thank you.

Mr. BUSH. Mr. Chairman, I have received a letter from Marvin E. Mergele, D.D.S., with respect to H.R. 5710 which he asked to be brought to the attention of the committee and inserted in the record. I would like to ask permission to include Dr. Mergele's letter at this point in the record of the hearings.

The CHAIRMAN. Without objection, it will be so done.

HOUSTON, TEX., March 17, 1967.

HON. GEORGE BUSH,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN: As the director for dental public health activities in the Houston area and as such, a spokesman for the local dental profession on public health matters, I would like to solicit your support for H.R. 5710 now in the process of holding hearings by your Committee on Ways and Means.

The dental care provisions of this bill, if enacted, would give the many thousands of impoverished youngsters in the Houston community, the necessary relief from the dental ills they are now experiencing and provide them with the opportunity to lead a reasonably happy and health life. We furthermore believe that the administration for a National Dental Health Program For Children should be put in the hands of the agency most qualified to handle dental matters, namely the Division of Dental Health, U.S.P.H.S. May I request that the contents of this letter be inserted into the records of the hearings?

The members of the dental profession are delighted to have you represent us in Washington and assure you of our continued support.

With kindest personal regards, I remain

Respectfully yours,

MARVIN E. MERGELE, D.D.S.

The CHAIRMAN. Our next witnesses are Mr. Gerald M. Flynn and Mr. Zalman J. Lichtenstein.

STATEMENTS OF ZALMAN J. LICHTENSTEIN, EXECUTIVE DIRECTOR, SENIOR CITIZENS GOLDEN RING COUNCIL, AND GERALD M. FLYNN, ADVISER; ACCOMPANIED BY HERMAN L. SAINER, ADVISER

Mr. LICHTENSTEIN. Mr. Chairman, my name is Zalman J. Lichtenstein, of the Gold Ring Council of Senior Citizens, and we are privileged and honored to be here as witnesses and participants in this great legislative process.

Mr. Chairman and distinguished members of the House Ways and Means Committee, the dentist and the other gentleman spoke about children for about half an hour. These are our grandchildren and great grandchildren, and now we want to talk about ourselves, the parents, the grandparents, the great grandparents.

It fits in very nicely. We like it. We love it that your committee is taking up the problems of our children, our grandchildren, and ourselves. A young elderly lady of our group—and we are 249 representatives of senior citizens organizations of all kinds, all walks of life, former businessmen, workers, self-employed, all kinds of groups, labor groups, church groups, and so on—told me, “I would like to say something to the Congressmen,” and each of them has something to say from her or his own experience, but I told the lady, “We have only 15 minutes. You cannot talk. The chairman and the committee would have to agree to sit for days and nights to listen to your stories on social security benefits and medicare and medicaid. Only one person can talk,” so the lady said to me, “So what do we have to do.”

And I told her, “Do one thing. Look into the eyes of the Congressmen, the gentleman from Arkansas, and the gentleman from Pennsylvania, and the gentleman from Wisconsin, and the gentleman from Missouri, and so on. Look into their eyes and they will look into your eyes and they will realize and see your dreams and your aspirations and your needs,” so for the next 15 minutes I am asking my people, the elderly people, the ladies and the gentlemen, look into the eyes of the Congressmen and that will be more than talk, more than words, and the only gentleman who is going to present our case, Mr. Chairman, with your permission, will be my good friend Gerald M. Flynn, who is the welfare officer of the railroad people and the adviser to the senior citizens.

Thank you very much again for the privilege that you gave to us. Since 1959 we have been coming over here. We are not going back empty handed. If not with a full bag, we will go back with something, always with something, and now, Mr. Chairman, Mr. Flynn would like to tell you our story.

The CHAIRMAN. Thank you, Mr. Lichtenstein. Mr. Flynn, you are recognized, sir.

STATEMENT OF GERALD M. FLYNN

Mr. FLYNN. Thank you very much, Mr. Chairman and members of your committee. I am Gerald M. Flynn, administrator of the Long Island Trainmen's health and welfare program and director of the

Senior Citizens Council of Railroad Trainmen of the Long Island Railroad, of Jamaica, N.Y.

I am here today to join with Mr. Zalman J. Lichtenstein, adviser to the Golden Ring Council of Senior Citizens, with clubs of elderly people in many States of the Union, and with Mr. Herman L. Sainer, of the National Jewish Welfare Board, adviser to the Senior Citizens Council of Greater New York.

Appearing with us in the audience are 249 senior citizens from New York, Pennsylvania, New Jersey, and Maryland. They represent elderly people of all walks of life, former businessmen, workers, and self-employed.

WE SUPPORT A 20-PERCENT AVERAGE RISE IN SOCIAL SECURITY BENEFITS

We would like to state right at the outset that we are whole heartedly supporting President Johnson's suggested improvements in the Social Security Act, and especially the amendments concerning the retirement benefits increase embodied in the Mills bill, H.R. 5710.

In our prosperous United States the recommended increase of the minimum benefit to \$70, and benefits increased across the board to all beneficiaries by at least 15 percent is long overdue.

When the social security law was first passed in 1935, the taxing wage ceiling for the social security trust fund of \$3,000 annually represented at that time approximately 95 percent of the salaried income paid in the United States. We feel that the taxable ceiling of \$10,500 proposed by President Johnson and Chairman Mills will barely restore the value of the above taxable base to the law. This will help the retirees of today and even more so the retirees, the disabled, and the survivors of tomorrow.

AGAINST REDUCING PRESENT TAX EXEMPTION FOR PEOPLE OVER 65

We must state our reservations to the proposal for reducing tax exemptions for people over 65.

We are opposed to crediting any portion of the social security annuity as income for taxing purposes under the Internal Revenue Service. We feel that raising the monthly benefits, increasing the taxing base of working individuals on the one hand and then on the other hand taking some of this money away as income taxes is double taxation and would defeat the very purpose of the social security pension system.

MEDICARE CALLS FOR IMPROVEMENTS

With your permission, Mr. Chairman, we would like to discuss more thoroughly the workings to date of the medicare program.

With reference to title XVIII of the Social Security Act, we were delighted to learn in 1965 that the distinguished Ways and Means Committee under your leadership, Chairman Mills, was ready to report out a medicare hospital bill and quite surprised to know that in addition to the basic hospitalization coverage you were also reporting out a supplementary insurance program.

We thought then that the many years of hard work were resulting in a successful accomplishment for all concerned. As of now, however, we must state with regret that many of our hopes and expectations did not yet materialize.

Let us be more specific.

Before July 1, 1966, the average senior citizens in our Brotherhood of Railroad Trainmen, for example, was paying \$7.84 a month for 120 days of hospitalization and \$500 surgical rider, which covered in-hospital medical care, in-hospital and office surgical procedures, anesthesiology and diagnostic radiology procedures.

Of this \$7.84, \$1.68 was allocated to the Blue Shield coverage and \$6.16 to hospital coverage. This member was assured that a hospital admission that extended up to 120 days would be paid in full by the Associated Hospital Service of New York with no additional charges to the member.

FOR ELIMINATING THE DEDUCTIBLES

After medicare went into effect on July 1, 1966, the member found that upon entering the hospital he was required to pay for the first day, in the amount of \$40. He understood that this was required by law.

However, in addition to the \$40, it is demanded of him that he pay now in advance an additional \$60 to \$70 for so-called professional fee charges, items not included formerly in the hospital charges under Blue Cross.

We now submit documents concerning a medicare patient who paid out-of-pocket expenses of \$113.20 for an 11-day stay in addition to the initial \$40 charge, for a total of \$153.20. We should like to present as part of this exhibit a hospital bill which indicates that one patient, under Blue Cross, was charged one fee for semiprivate accommodations, and a medicare patient was charged a \$5 a day higher fee for like services, like facilities, in the same hospital, only a few days apart and here they are, Mr. Chairman, right here.

HOSPITAL ACCOUNTING TAKES MEDICARE FOR A RIDE

We feel with reference to the medicare program itself that overcharging and loss to the social security hospital fund have been condoned under the guise of separate accounting procedures. The daily charge for professional services by the hospital for interns and residents in the amount of 5 percent, separating part of the operating room charges for professional services in the amount of 25 percent, separation of laboratory fees for professional services in the amount of 2 percent, separation of X-ray services in the amount of 40 percent, and the separation from the hospital bill (which in many cases had previously been part of the hospital charge) of anesthesiology, pathology, and, as mentioned above, radiology has partially invalidated the medicare program itself.

We further feel that the continuation of the initial daily charge of \$40 against the patient, supposedly a deterrent against overuse of hospital facilities, should be completely eliminated and the aforementioned

tioned professional charges, that have traditionally been part of the hospital bill, should once again be included as part of the hospital charge.

We feel the same way about the \$50 deductible in the supplementary plan B program. We think it is also unjust, too complicated, and a carryover from the insurance industries thinking that a front-end deductible would be a deterrent to overusage, when the fact of the matter is that we are not trying to prevent people from using medical care but rather to take care of pressing health needs.

Now the senior citizen, who previously paid \$4.08 a year for a Blue Cross/Blue Shield contract (and I grant you he did not receive as many benefits as he would under medicare) before he receives one bit of service under the new medicare program, he must pay \$126 a year.

We are certain that the cost studies by the administration of this \$40 charge for the hospital and the \$50 deductible in supplementary plan B will prove to be so high that the so-called savings are insignificant.

In addition, we think the fee schedule that has been established for medical and surgical treatments, even though it is supposed to cover 80 percent of the doctor's fee, is a very liberal allowance.

In fact, with our \$500 surgical allowance program, insured with the United Medical Service of New York City, we find that the fees are in many cases 20 percent greater and in most cases 100 percent higher than what the doctor is receiving for workmen's compensation cases.

We believe the administrative staff, under the direction of Under Secretary Wilbur Cohen and Commissioner Robert Ball should be complimented on the fine job they have done in enrolling and processing the people who are eligible for medicare coverage. The matter of the purveyor of benefits has not kept pace with the fine accomplishments of the Social Security Administration.

The program at the present time is not functioning smoothly. There are delays of anywhere from 60 to 120 days before claims for payment are processed, and in many cases claims have not been paid since July 1966.

We know that doctors throughout the country are not cooperating with the program. We know that the powerful union—the American Medical Association (which at the present time is not covered by the Taft-Hartley or Landrum-Griffin laws) is not encouraging its members to cooperate. At best they offer only minimal cooperation with title XVIII and title XIX. Consequently so many of our senior citizens have their money, needed for daily living expenses, tied up in paying doctor bills, waiting for the medicare purveyor to reimburse them.

DOCTOR FEES SKYROCKETING

We think that the fair and reasonable fee concept espoused in the law, has resulted in general increases in medical fees throughout the country, of at least 20 percent and in some cases higher. These increased costs have been passed on to all members of the community and consequently, the negotiated dollar of the welfare fund is now found to be inadequate and many welfare programs are in distress.

In the metropolitan area of New York City, including Nassau and Suffolk Counties, it has resulted in different fees being paid in the seven counties. We know that the fair and reasonable fee as applied to Brooklyn and Manhattan is higher than in surrounding counties.

Therefore, it is not unusual to find that doctors who have had for many years visitation rights to hospitals in New York City, but did not use them, and did 99 percent of their work in the proprietary hospitals in Queens, Nassau, and Suffolk Counties, now find it very lucrative and worthwhile, despite the additional time and effort of traveling to Manhattan, to transfer their cases to these facilities.

SURGICAL FEES

I did want to say something that is not in this statement about the surgical fees. I have given this a lot of thought as a layman from the outside. I think what we should have is a reasonable fee schedule for a larger geographical area than the county as we have it in the New York City area at the present time.

This may be a help to expediting the whole matter of treatment by the doctors.

DRUGS BY GENERIC TERM

We hope that this committee will give serious consideration to the President's suggestion to have drugs included by their generic term. We find in many cases of chronic heart disease, arthritic diseases and such that require constant medication, that these costs have risen tremendously.

If the committee is not desirous of including these items under supplementary plan B, perhaps legislation enabling the Department of Health, Education, and Welfare to establish drugstores or permit medicare patients to purchase their drugs at various Federal hospitals and installations, once again under their generic term, would partially alleviate the problem.

MEDICARE FOR THE DISABLED AND THE SURVIVORS

We are fully in favor of the President's recommendation to include in the medicare program the disabled. In our opinion also the health of the survivors should be protected by medicare.

In conclusion, we would hope, Mr. Chairman, that you and your distinguished committee will give serious consideration to all aspects of our presentation.

Thank you for your courtesy and attention.

The CHAIRMAN. We thank you, Mr. Flynn and Mr. Lichtenstein for coming to the committee this morning.

Are there any questions? If not, we thank you very much.

Mr. FLYNN. Thank you very much, Mr. Chairman.

The CHAIRMAN. The National Association of State Mental Health Program Directors, the American Psychiatric Association, and the National Association of Private Psychiatric Hospitals represented by Dr. Ganser and Dr. Gibson.

Dr. Ganser, are you delivering the statement?

STATEMENTS OF DR. LEONARD GANSER, VICE PRESIDENT, NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS AND DR. ROBERT GIBSON, AMERICAN PSYCHIATRIC ASSOCIATION AND NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS; ACCOMPANIED BY HARRY SCHNIBBE, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS, AND MARGO COHN

Dr. GANSER. Yes, sir.

The CHAIRMAN. If you will identify yourself for the record and those at the table with you we will be glad to recognize you, sir.

Dr. GANSER. I am Dr. Leonard Ganser, director of the Division of Mental Hygiene of the Department of Public Welfare of the State of Wisconsin and also vice president of the National Association of State Mental Health Program Directors.

We wish to thank you for the opportunity to appear before this committee with reference to H.R. 5710. In the interest of saving time this testimony will combine the testimony of three organizations, the National Association of Private Psychiatric Hospitals, the American Psychiatric Association, and the National Association of State Mental Health Program Directors.

With your permission, I would like to ask Dr. Robert Gibson, the medical director of the Sheppard & Enoch Pratt Hospital in Towson, Md., to give a statement which represents the statement of the National Association of Private Psychiatric Hospitals and the APA.

The CHAIRMAN. Dr. Gibson.

STATEMENT OF ROBERT W. GIBSON, M.D.

Dr. GIBSON. I am honored to have this opportunity, Mr. Chairman, to speak to you in behalf of the American Psychiatric Association, whose 15,000 members have the primary responsibility for the medical treatment of the mentally ill in our country, and to speak on behalf of the National Association of Private Psychiatric Hospitals, whose 136 member hospitals have the primary responsibility for the private hospital care of the mentally ill.

I should like first to express the gratitude of our profession for the very significant progress that has been made of the inclusion of broad benefits for the treatment of the elderly mentally ill under Public Law 89-97.

The psychiatric profession has hailed as a major breakthrough those provisions of both title XVIII and title XIX that permit treatment of the mentally ill person over 65, in a general hospital, a private psychiatric hospital, a State mental hospital, or a community mental health center.

In short, these provisions make it possible for the psychiatrist to utilize the full range of modern psychiatric facilities for the treatment of the older patient.

So, gentlemen, when I speak of our disappointment with some of the provisions regarding the mentally ill, and our hope that these provisions can be modified, I should like to make it clear that psychiatrists

are appreciative of the progress that has been made in providing benefits for the treatment of mental illness in our older citizens.

But, we are particularly concerned by the severe restrictions of title XIX imposed on the treatment of the mentally ill person under 65.

Let me briefly review the benefits for the mentally ill under title XIX. For the person over 65, deemed medically indigent, State plans can supplement title XVIII by meeting the cost of deductibles, by going beyond the 90-day limit for a single spell of illness, and by going beyond the 190-day lifetime limitation for psychiatric care.

Such patients may be treated in an institution for the mentally ill or in the psychiatric unit of a general hospital. These are the persons over 65.

Title XIX also provides medical assistance for persons under 65 who are in families with dependent children, are blind, or are permanently and totally disabled and whose income and resources are insufficient to meet the costs of necessary medical services. Recipients under the age of 65 may receive in-patient psychiatric treatment but only on the psychiatric unit of a general hospital. They may not receive such treatment in a mental institution, whether it be a public or private mental hospital, or even a community mental health center.

This limitation is highly objectionable. Not a single State in our country has a sufficient number of psychiatric units in general hospitals to treat the persons now eligible for benefits under title XIX. Many States have virtually no psychiatric units in general hospitals.

Let me be specific. The most recent surveys of the American Psychiatric Association show that there are no psychiatric units in general hospitals in Alaska and Wyoming; only one unit in a general hospital in Delaware, Idaho, Maine, and New Hampshire; only two units in Arkansas, Hawaii, Montana, Rhode Island, Vermont, Arizona, and New Mexico; and only three units in Nevada, South Dakota, Mississippi, and Oregon. These 17 States have only a handful of beds that could begin to treat the patients eligible under title XIX.

Furthermore, the psychiatric unit of a general hospital provides only a limited spectrum of care. Such services are primarily diagnostic and limited to brief stay, usually measured in days. They seldom have the full range of specialized mental health professionals needed to rehabilitate the patient suffering from a psychiatric illness. The shortage of facilities equipped and staffed to treat children is particularly severe.

I want to emphasize that the psychiatric unit of a general hospital does serve a valuable function in the treatment of the mentally ill, but it has a specialized role and cannot be considered an equivalent or a substitute for the programs of the State hospitals, the private psychiatric hospitals or the community mental health centers.

We do not ask you to include more persons under title XIX. We do not even ask you to expand the benefits under title XIX. We do ask that you make it possible for eligible persons to get the treatment to which they are already entitled. To do this, you must include all the properly qualified institutions. We want the definition of a hospital to include the public mental hospital, the private psychiatric hospital, and the community mental health center.

This would mean deleting the phrase that is a limiting phrase saying, "other than services in an institution for * * * mental diseases." Public Law 89-97, title XIX, section 1950(a)(1).

Treatment in a public mental hospital, a private psychiatric hospital and the community mental health center was included by the Congress under title XVIII, and the failure to do so under title XIX is fundamentally inconsistent and wholly out of tune with the new approach implicit in community psychiatry which the Congress has so vigorously supported.

I would now like to address myself briefly to title XVIII, which does provide broad benefits for the mentally ill person over 65. Under the supplementary medical insurance benefits for the aged, outpatient treatment may be paid for after a \$50 deductible, with the patient paying 20 percent, and with no top limit.

But, in the case of psychiatric outpatient treatment, the patient must pay 50 percent after the deductible, and there is a top limit of \$250. This limitation seriously curtails outpatient psychiatric treatment for the aged patient. Many elderly patients can be successfully treated on an outpatient basis. If such treatment is denied because of financial limitation, the inevitable result will be hospitalization.

Such unwarranted hospitalization may not serve the best interests of the patient, and will most certainly add to the cost of the hospital insurance program.

Thus we ask for the elimination of discriminatory provisions limiting outpatient psychiatric care for the treatment of the aged under title XVIII. This would mean deleting the phrase:

(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic and personality disorders as an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b) only whichever of the following amounts is smaller: (1) \$312.50 or (2) 62½ percent of such expenses, P.L. 89-97, Title XVIII, Section 1833, (c).

Again addressing myself to title XVIII, there is a 190-day lifetime limit placed on treatment in a psychiatric hospital. No such limit is placed on treatment in a general hospital, even if such treatment in the general hospital is for a psychiatric illness. It makes no sense to force a patient, after an arbitrary period of time, 190 days, to shift from one institution to another for the treatment of the same mental illness. And that is exactly what can happen.

We realize that the 190-day lifetime limitation grew out of the fear that psychiatric treatment of the aged is generally just custodial, but the facts show that such an assumption is totally unfounded.

Studies which I have conducted of aged patients in private psychiatric hospitals indicate that approximately 80 percent of these patients improve sufficiently within 60 days to return to their homes.

Therefore, we ask you to eliminate the 190-day lifetime limit on treatment in a psychiatric hospital under title XVIII. This would mean deleting the phrase "(3) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime." Public Law 89-97, title XVIII, section 1812(b).

At the very least we urge that immediate studies of psychiatric hospital utilization be made because we are convinced that these studies will show that the 190-day lifetime limit is unwarranted. Our professional psychiatric associations pledge their cooperation in making such studies.

In conclusion, let me repeat that the American Psychiatric Association and the National Association of Private Psychiatric Hospitals, consider this legislation a momentous advance in meeting the health needs of the American people. But, at the same time, we cannot rest until our mentally ill citizens are accorded the same identical benefits provided for citizens who suffer from other illness. We do not ask that more persons be included under title XIX nor do we ask that more benefits be granted.

We ask simply that the Congress amend the social security legislation so that all qualified institutions—State and private mental hospitals, and community mental health centers—can provide the psychiatric treatment so desperately needed.

We ask that title XVIII be amended to permit outpatient treatment for a psychiatric illness to be carried out on the same basis as treatment for any other illness. We ask that the 190-day lifetime restriction on treatment of the aged in a psychiatric hospital be eliminated.

We ask for no special privileges, but we do ask for an insurance and benefit system that would enable the profession of psychiatry to provide the right kind of treatment, at the right time, and at the right place, for all persons deemed eligible for health benefits.

Our associations pledge their wholehearted support and cooperation to the Congress and to the public and private agencies in making such an equitable system fully workable and maximally effective. This is the principle on which we stand, and we hope we have your sympathetic ear.

Now, Mr. Chairman, Dr. Ganser will complete our statement.

The CHAIRMAN. Dr. Ganser.

STATEMENT OF LEONARD GANSER, M.D.—Resumed

Dr. GANSER. Mr. Chairman, I would like to identify two other people here at the table before I proceed. Mr. Harry Schnibbe, who is the executive director of the National Association of State Mental Health Program Directors, and Margo Cohn of his staff.

I am representing the directors of programs for the mentally ill and retarded in the 54 States and territories.

The State mental health directors administer over 1,100 hospitals, training schools for the retarded, community mental health centers, clinics, aftercare facilities and psychiatric training and research institutions; 1.5 million mentally disordered persons are treated in our facilities annually.

We employ 284,000 persons and our annual operating and capital budgets total \$2.3 billion, which is larger than the 1968 combined administrative budgets of the U.S. Departments of State, Justice, Labor, and Post Office.

PROPOSED AMENDMENT

We propose an amendment to title XIX of the Social Security Act as follows:

In Public Law 89-97, at the end of section 1905(a)(1), after "inpatient hospital services", strike out the phrase, "(other than services in an institution for tuberculosis, or mental diseases)".

This amendment would not change the eligibility provisions of title XIX coverage. It would not expand any benefits now available under title XIX (mental illness is now treatable with Federal assistance.)

It would simply broaden the availability of treatment for those already eligible by removing the exclusion against hospitals that specialize in treatment of mental illness (or tuberculosis).

THE PRESENT LAW

Title XIX now provides Federal assistance for medical treatment of the medically indigent (a) aged, (b) blind, (c) disabled, and (d) families of dependent children.

Under title XIX the aged are given full inpatient psychiatric coverage in public and private psychiatric hospitals as well as in psychiatric units of general hospitals. They are also eligible for full outpatient treatment.

However, the other three assistance groups (the blind, the disabled, and the dependent children families) are excluded from inpatient treatment in a specialty hospital.

They can receive inpatient treatment only in a general hospital.

SHORTCOMINGS IN LAW

There are several inconsistencies in the title XIX exclusion.

First. In terms of availability of inpatient treatment service—there are probably less than 20,000 beds being used for psychiatric inpatient treatment in general hospitals.

On the other hand, in public hospitals for the mentally ill and mentally deficient there are 665,000 available beds.

Dr. Gibson has described to you the severely limited general hospital psychiatric facilities in some 20 States.

May I add to that this information: In the 3,500 small general hospitals in this country—that is hospitals with less than 100 beds—there are only seven psychiatric treatment units.

If the Congress is going to offer support of treatment for mental illness, then it appears totally inconsistent to exclude two sources (the private and public psychiatric hospital) that offer 35 times more available treatment capacity than the one authorized source, the general hospital.

Second. In terms of continuity of service many of the chronically mentally ill need intensive treatment over a period of time more extended than that provided in a general hospital.

As Dr. Gibson has pointed out, the general hospital provides largely diagnostic and acute treatment service.

The average length of stay in a general hospital psychiatric unit is 17 days.

And over 25 percent of all patients admitted are eventually re-admitted for further treatment.

The "specialty" hospitals (both private and public) are designed, staffed, and equipped to provide a continuity of care for people with all ranges and severity of mental illness and mental deficiency.

We treat the acutely ill and the chronically ill; the psychotic, the neurotic; adults and children; the alcoholic, the aged, and the disabled.

We are "specialty" hospitals whose treatment programs are completely focused on alleviating disorders of the mind. It makes no sense at all, to us, for the Congress to prohibit the treatment of persons with mental disorders in facilities whose sole purpose is the treatment of mental disorders.

This is an inconsistency difficult for use to fathom.

ANOTHER INCONSISTENCY

It is worthwhile to note that some \$150 million in Federal money will be invested this year in public and private psychiatric hospitals.

For the Federal Government to lend extensive financial support to State and private hospitals and then deny access to these hospitals to recipients of Federal assistance is an incomprehensible inconsistency.

In the prepared material there is a table indicating this \$150 million which I would like to merely submit for the record.

(The information referred to follows:)

FEDERAL MONEY DISTRIBUTION TO PUBLIC AND PRIVATE PSYCHIATRIC HOSPITALS

The aforementioned \$150 million will be invested in public and private psychiatric hospitals in the following manner:

	<i>Millions</i>
Hospital improvement grants-----	\$18
Department of Defense dependents: Medical care program-----	¹ 13
Training (in service)-----	12
Hill-Burton-----	4
OEO (Vista, etc.)-----	8
Community mental health services (Public Law 89-749)-----	7
Community mental health centers-----	50
Community mental health staffing-----	46
Total -----	158

¹ Estimated.

HOW MANY AFFECTED BY DISCRIMINATION?

Dr. GANSER. A most logical question by members of this committee would be: How many persons suffering from mental disorder are affected by these discriminatory provisions in title XIX, and if it were removed what would it cost to provide them treatment?

We have some information on how many persons are suffering from mental disorders who are receiving assistance under title IV, X, and Federal aid under the three pertinent public assistance categories, other than "aged."

There are 367,243 persons presently diagnosed as suffering from mental disorders who are receiving assistance under titles IV, X, and XIV of the Social Security Act.

All of these persons would become eligible for treatment in hospitals for mental diseases under our proposed amendment. At the same time they can receive inpatient psychiatric treatment only in a general hospital and have the Federal Government support part of their treatment costs.

We do not know precisely how many medically indigent persons "related" to the public assistance categories, blind, permanently and totally disabled, families of dependent children, might be seeking treatment for mental disorders.

However, we are able to estimate the total number of "categorically related" medically indigent persons (who can be expected to require treatment for mental disorder.)

The records of several of our States indicate that the ratio of medically indigent persons who are "related" to the three pertinent public assistance categories—blind, disabled, dependent children—but who are not now receiving any public assistance is: 1 to 1.

In other words, for every blind person receiving title X Federal assistance, there is another blind person not receiving public assistance, but who is "medically indigent" as defined by State law. If the 1 to-1 ratio is correct and if it also holds for mental disorders, then we are talking about a group of people totaling twice 367,243—or a grand total of 734,486 persons.

With reference to those known to be suffering from mental disorders, now receiving public assistance, we again have a page of material Mr. Chairman, that we would like to submit for inclusion in the record.

The CHAIRMAN. All of this material will be included in the record. (The material referred to follows:)

TITLE IV.—*Aid to families of dependent children*

Father—Not working due to major impairment of mental, psycho-neurotic, and personality disorders-----	23, 330
Mother:	
In home but not employed because of mental disability-----	30, 000
In mental institution-----	5, 371
Child:	
Suffering from mental retardation-----	72, 303
Suffering from emotional and other nervous disorders-----	92, 468
Subtotal -----	<u>223, 472</u>

TITLE X.—*Aid to the blind*

Mental retardation -----	4, 394
Psychosis, psychoneurosis, or personality disorder-----	1, 974
Subtotal -----	<u>6, 323</u>

TITLE XIV.—*Aid to the permanently and totally disabled*

Primary impairment:	
Mental retardation -----	61, 695
Schizophrenia, psychoneurotic disorders, and other psychosis-----	46, 860
Secondary impairment:	
Mental retardation -----	12, 330
Schizophrenia, psychoneurotic disorders, and other psychosis-----	16, 563
Subtotal -----	<u>137, 448</u>
Total -----	<u>367, 243</u>

COST OF THE AMENDMENT

Dr. GANSER. The proposed amendment adds no new benefits and includes no persons not already eligible for medical aid under Public Law 89-97. Any person now presently eligible for medical aid under title XIX, who becomes mentally ill and requires inpatient treatment, can be treated for about \$45 per day in one of the 20,000 beds available in psychiatric wards in general hospitals.

He can be treated providing: (a) he lives near one of the 465 general hospitals in the United States that operates psychiatric facilities, and (b) space is available, and (c) he does not require extended treatment.

Otherwise that mentally ill person is unable to take advantage of the aid now offered under title XIX.

On the other hand the private and public hospitals specializing in treatment of mental disorders have almost 700,000 beds available—with no waiting lists—in every part of the country.

With the adoption of our amendment eligible title XIX medical aid recipients would also be able to utilize the services of public and private psychiatric hospitals and receive benefits there.

The costs in the public hospitals generally averages less than \$12 per patient-day—In the private hospitals the average cost is less than \$30 per patient-day. At the same time, the quality of the acute or intensive treatment programs in most public and private hospitals for mental disorders compares favorably to that provided in the psychiatric section of a general hospital, considering, especially, the rather specialized nature of the treatment afforded in general hospitals, as contrasted to the broad range of treatment services available in mental hospitals.

There is another factor that must be considered involving cost of treatment to the individual patient. It must not be assumed by the Congress that by paying for care in a State mental hospital the Federal money is merely displacing State money. An individual patient—or certain members of his family—is held liable for payment for services provided in most State hospitals, and this liability follows the patient after his discharge.

Federal assistance in providing the resource for payment of the medical costs incurred by a mentally ill indigent person who is treated in a public mental hospital is providing a direct benefit to the individual.

Acceptance of the amendment we have offered today benefits the medically indigent sick person—not the State.

CONCLUSION

Mr. Chairman, the State mental health directors as far back as May 12, 1961, publicly asked the Congress to eliminate from the Social Security Act all discriminatory provisions against the treatment of mental disorders.

Following our action the Governor of California called upon all the other Governors to join him in getting the exclusions against mental hospitals removed from the act. Over the next several years Senators Long of Louisiana and Carlson of Kansas tried and failed to get the discriminatory provisions removed.

Senate amendments, removing the exclusions, were included in H.R. 11865, the Social Security Act Amendments of 1964. They failed in conference with the House.

Finally in the 89th Congress, Public Law 89-97, most of the exclusions were removed and the action for their removal originated in this committee. The last vestiges of discrimination in Federal welfare programs against patients in specialty hospitals remain in section 1905 of Public Law 89-97.

There are other discriminatory provisions in title XVIII that Dr. Gibson has called to your attention.

But, we ask you, at this time, to take at least this one step, and remove once and for all the remaining provision in title XIX that is prejudicial to full, immediate, and good quality treatment of mental disorders among the medically indigent.

Mr. Chairman, we ask that your committee give favorable consideration to our proposed amendment.

The CHAIRMAN. We thank you, Dr. Ganser and Dr. Gibson, for bringing your statements to the committee this morning.

Are there any questions of these gentlemen?

Thank you very much.

Dr. GANSER. Thank you.

(The following letters were received by the committee:)

NATIONAL ASSOCIATION OF STATE MENTAL
HEALTH PROGRAM DIRECTORS,
Washington, D.C., March 17, 1967.

Hon. WILBUR MILLS,
House Office Building,
Washington, D.C.

DEAR CONGRESSMAN MILLS: We appreciate the attention which you gave to the testimony of Dr. Ganser on behalf of our Association on March 13.

As you will remember Dr. Ganser proposed an amendment to Title 19 of the Social Security Act to remove a provision that is discriminatory against public and private psychiatric hospitals.

As Dr. Ganser pointed out, this severe discrimination works against both the best interests of the mentally ill patient and the federal medicaid program.

Your committee in the past has led the way in removing the discriminatory provisions against mental disorders in federal health legislation. Will you help us to remove this last vestige of discrimination in Title XIX?

A copy of our proposed amendment is enclosed.

Sincerely,

WILLIAM E. SCHUMACHER, M.D.,
President; Director, Bureau of Mental Health, State of Maine.

AMENDMENT TO THE SOCIAL SECURITY ACT PROPOSED BY NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

The Social Security Act, Title XIX, Section 1905 reads in pertinent part as follows:

"SEC. 1905. For purposes of this title—

"(a) The term "medical assistance" means payment of part or all of the cost of the following care and services. . . .

"(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases) ;"

* * *

It is proposed that the following phrase be stricken out: "(other than services in an institution for tuberculosis or mental diseases)."

This Section 1905(a) (1) would read simply:

(1) inpatient hospital services;

AMERICAN PSYCHIATRIC ASSOCIATION,
Washington, D.C., April 12, 1967.

Hon. WILBUR D. MILLS,
Chairman, House Ways and Means Committee, House of Representatives,
Washington, D.C.

DEAR MR. MILLS: This letter addresses itself to proposals to amend Title XVIII of the Social Security Act to provide for payment for psychologists' services under the program of supplemental medical insurance benefits for the aged. At present these services are reimbursable only if they are incidental to a physician's service or are performed on referral from a physician.

Our Association cannot support this amendment, though our opposition in no wise demeans the vital role of psychological services in the Medicare Program. We seek meaningful collaboration with them in all possible ways to further the national program to combat the mental illnesses, and we use the term "meaningful collaboration" advisedly.

There are many kinds of professionals who play a vital role in our field. Among them are clinical psychologists. There is also the clergyman who counsels his disturbed parishioner, the lawyer who seeks to reconcile a couple on the verge of divorce, the social worker who strives to knit together a shattered family, the teacher who fosters the growth of a troubled pupil, not to mention a range of vocational, educational, and personnel counselors and others who work to bring troubled people into better rapport with the world about them.

Moreover, each has a certain kind of professional training and competence. If the psychologists are to be singled out for independent status in the Medicare Program in the context of an amendment, then why not several others by extension? If that were to happen, "Medicare" would become "Sociocare."

The real issue, as we see it, is not whether the psychologists are to play an ever more telling role in combatting the mental illnesses in Medicare and other programs across the board and be properly compensated for their services. It is rather whether we are going to continue to rely on medical services in the treatment of mental illnesses as the primary framework within which we will carry on the struggle to overcome them; or, to put it another way, whether Medicare as a medical program for the aged is to transmute into a non-medical program.

There is a significant body of thought within the ranks of clinical psychology which questions the validity of traditional reliance on the medical service system altogether. Its exponents would remove the training of clinical psychologists from medical settings where it takes place at present and establish a wholly independent curriculum content and methodology. They would substitute for general hospitals and medical service what they sometimes called the "human effectiveness model," and they would establish independent and "pure" psychological services for dealing with many of the mental illnesses. As we see it, such conceptual initiative is reflective of a vigorous, dynamic, and burgeoning young science to be applauded and encouraged. But one may understandably be circumspect about translating such new and untested concepts into actual services for the mentally sick people.

There is also the simple and inescapable fact, always with us, that hundreds of thousands of mentally ill people do actually need medication and other medical treatments and hospitalization. For this reason alone, it is impossible for us to entertain the proposition that non-medically trained persons should independently engage in a practice without referrals by physicians who continue to collaborate with other professions.

We would instead vigorously urge that the promise of the future lies in making "meaningful collaboration" among the several professions concerned ever more meaningful, and psychiatry will not be found wanting in furthering this end.

Sincerely,

HARVEY J. TOMPKINS, M.D.,
President.

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS,
DEPARTMENT OF SOCIAL WELFARE,
Providence, R.I., March 27, 1967.

HON. WILBUR MILLS,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN MILLS: The National Association of State Mental Health Program Directors has proposed an amendment to the Social Security Act, Title XIX, Section 1905(a) (1). The proposed amendment would delete the following phrase "(other than services in an institution for tuberculosis or mental diseases)." This change would eliminate inconsistencies in the present law.

The proposed amendment would not expand any benefits now available under Title XIX but would simply broaden the availability of treatment for those already eligible by removing the exclusion against hospitals that specialize in the treatment of mental diseases or tuberculosis.

On March 13, 1967 Dr. Leonard Ganser appeared before the House Ways and Means Committee in support of the amendment.

The Rhode Island Department of Social Welfare would like to go on record as endorsing the statement of Dr. Ganser and supporting the amendment.

Sincerely,

AUGUSTINE W. RICCIO, *Director.*

The CHAIRMAN. We have our colleague, the Honorable Bernie Sisk present this morning to introduce our next witness. Would you please come forward, Mr. Sisk? We are pleased to have you with us this morning. You are recognized.

**STATEMENT OF HON. B. F. SISK, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF CALIFORNIA**

Mr. SISK. Thank you, Mr. Chairman. I appreciate this opportunity and I will only take a very brief time and then introduce Dr. Chapman for a statement on behalf of the Optometric Association.

Mr. Chairman, while your hearings, as I understand, will, of course, deal primarily with H.R. 5710, your bill, it is my understanding that the committee will consider all bills that have been referred to it that are designed to amend the social security law.

On January 12, I introduced H.R. 1261 which will make available to title XVIII beneficiaries the services of optometrists which come within the scope of their practice as defined by the law of the State in which the services were rendered.

There are some 2,500 licensed optometrists practicing in California. California was one of those States which greatly benefited by the 1950 amendment to title X of the social security law (aid to the blind program). Services provided by our optometrists have greatly facilitated and improved the effectiveness of California's aid to the blind program. I believe beneficiaries should be free to go to an optometrist for authorized services without first having to secure a certificate from a physician or osteopath.

Last week, by the way, was designated as "Save Your Vision Week." Congress, by joint resolution approved December 30, 1963, requested the President to issue each year a proclamation designating the first full week of March as "Save Your Vision Week."

Permit me to call your attention to some of the statements in this year's Presidential proclamation and I quote:

Every fourth school child requires eye care. Every third serviceman needs glasses. Americans fear blindness more than any affliction except cancer. And every year 32,000 Americans go blind. Aid to the blind costs \$1 billion a year,

aside from the economic loss suffered by those who must try to find their way through lives of perpetual darkness.

Every American should cherish his God-given gift of sight, protect and care for his eyes, and support the research, diagnosis, and treatment that can save vision.

I call upon doctors, and private and public agencies to press on their work of saving, for us and our children, the incomparable blessing of sight.

A past president of the American Optometric Association, W. Judd Chapman, O.D. of Tallahassee, Fla., will present the views of the association and answer any questions you may have.

I will not take more of the committee's time. Before closing, I will point out that nine of my California colleagues have introduced bills similar to mine—both Republicans and Democrats. In fact, one bill has been introduced by a member of this committee, my good friend from the 35th District, Mr. James B. Utt.

I hope that you gentlemen and ladies of the Ways and Means will share the conviction held by those of us who have introduced legislation and amend H.R. 5710 to provide payment to optometrists for services already authorized under the act.

And, Mr. Chairman, it gives me a great deal of pleasure to introduce a very distinguished American, a very able practitioner, Dr. Chapman from Florida, who will make the presentation on behalf of the association and, if willing, I would like to step away and I know Dr. Chapman will not mind.

THE CHAIRMAN. We appreciate your being with us this morning, Mr. Sisk.

MR. SISK. I appreciate the courtesy of this committee.

THE CHAIRMAN. We are glad to have you, Dr. Chapman. You are recognized. If it is necessary for you to omit any part of your statement in order to stay within the time assigned to you, do so with the full knowledge that your statement and the material appended to it will be made a part of the record.

STATEMENT OF W. JUDD CHAPMAN, O.D., CHAIRMAN, LEGISLATIVE COMMITTEE, AMERICAN OPTOMETRIC ASSOCIATION, ACCOMPANIED BY WILLIAM P. McCRACKEN, WASHINGTON COUNSEL

DR. CHAPMAN. Thank you, Congressman Mills. I would also like to say to the committee that with me at the desk this morning is the Washington counsel of the American Optometric Association, Mr. William P. McCracken, Jr.

THE CHAIRMAN. We are glad to have you.

MR. McCRACKEN. Thank you, sir.

DR. CHAPMAN. I am Dr. W. Judd Chapman, a practicing optometrist of Tallahassee, Fla., here to speak for the American Optometric Association. The association is composed of approximately 14,000 optometrists who practice in all the 50 States and the District of Columbia. A past president of the association, I currently serve as chairman of the committee on legislation.

You have each been given a brochure, "Facts About AOA," which contains information about our association. The information is in-

tended to supplement my testimony, and I hope you will find time to read it.

My appearance before you today is to attempt to iron out an important, but otherwise small, wrinkle in the medicare legislation. Under the amendment I shall submit there will be no extra costs or benefits. It will simply provide that the patient can go directly to an optometrist for services already authorized in the act.

Optometric services are made available under title XVIII. But, despite the good intentions of Public Law 89-97, beneficiaries of title XVIII cannot obtain from optometrists services to which they are entitled. And even if they could, beneficiaries would first be required to go to a medical or osteopathic doctor to certify that the doctor of optometry's services are necessary. As you can well imagine, our patients believe this to be a very ironic situation.

Whenever an optometric claim is presented for payment, it invariably returns with the standard reply, "Physician—does not qualify under the definition of the law." Another way of saying the same thing was included in a letter regarding the Texas medicare program which said, "Under the law only the services of a medical doctor or a doctor of osteopathy are included."

I have seen hundreds of these rejection letters and not one is rejected for the reason that the claim was for a procedure excluded under the law. A few agencies have used as a reason for rejection, "Medicare does not pay for optometrists."

THE INDEPENDENT HEALTH PROFESSIONS

Before going further into the legislation before you, I would like to give you some background about the various professional providers of health services. There are only four lawful prescribers among the health disciplines whose training is qualified by the U.S. Office of Education and who are licensed in every State and the District of Columbia to examine, prescribe, and correct human deficiencies. These four are medicine, dentistry, optometry, and podiatry.

The 88th and 89th Congresses determined that each of these four health professions is critically short in manpower. All four professions participate in the Health Professions Educational Assistance Act and subsequent amendments.

To provide the quality and variety of health services envisaged by congressional enactments, all health professions must be used to their maximum legal capabilities.

So many people are confused by the terms optometrist, ophthalmologist, and optician, that I have attached a glossary to my statement for the benefit of those who would like a better understanding of them. I would like at this point to provide you with some additional background concerning optometry, as development, and the training of its students.

EDUCATION OF AN OPTOMETRIST

The practice of optometry as presently constituted has been determined by laws regulating and defining it; by court decisions interpreting these laws; by custom, practice, and public opinion; and by what has been and is now being taught in its schools and colleges.

Technically, optometry is the clinical application of physiological optics, the science of vision. Primarily dedicated to the enhancement of vision, optometry is also concerned with the preservation of vision, and thus accepts the responsibility for the intelligent referral of individuals with ocular and systematic diseases which are manifest in the eyes, and those in need of corrective surgery.

Optometric education today is based on a 6-year program of collegiate education, divided into two categories—preprofessional and professional training.

The preprofessional curriculum which may be completed at any accredited collegiate institution, consists of the same kinds of courses usually taken by premedical and predental students and includes: general chemistry, organic chemistry, analytical geometry, calculus, bacteriology, general physics, psychology, physiology, and biology. While all the requisite credit hours can be completed in 2 years, most students need 3 years to obtain all the courses prerequisite to professional optometry school admission.

Following admission into professional training, the optometric student is required to take 4 years of intensive work. First year studies include anatomy, ocular anatomy, geometrical and physical optics, general and mammalian physiology, physics, and microbiology. The second and third years add the clinical and optometric sciences to the advanced basic sciences.

For example, a student learns the vegetative functions of the eye, including such topics as the physiology of the cornea and lids; characteristics of drugs producing miosis, mydriasis, cycloplegia, accommodative spasm, and anesthesia of ocular surfaces; and biochemistry of the lens, iris, and pupil.

After study of normal function, it is natural to study abnormal function in pathology classes. These include a study of basic pathological processes in human development, senescence, and disease; a correlated survey of disturbed function in disorders of visceral systems, including disturbances of electrolyte and fluid balances and metabolism.

The fourth and final year is almost entirely clinical. It is during this year that the student applies under supervision all he has learned by helping patients obtain the most efficient vision possible.

Other courses such as optics, refraction, and the analysis of clinical data could be described, but I do not wish to make this presentation too long. The Ohio State University School of Optometry curriculum, attachment D, provides additional information on optometric education.

OPTOMETRIC EXAMINATIONS FOR PATHOLOGY

I want to emphasize that the optometrist is qualified to recognize the presence of disease by virtue of his training; he performs a careful and detailed examination to detect the presence of eye disease or symptoms of any general disease manifested in the eyes.

First the optometrist inspects the exterior of the eyes and lids and may measure pressure within each eyeball. Where the examination or the history indicates the need, he investigates the field of vision. By means of an ophthalmoscope—an instrument which shines a bright

light into the interior of the eye—he examines the optic nerve head and determines whether it presents a normal appearance. Do the blood vessels appear normal or are they constricted, tortuous, or otherwise abnormal? Have there been hemorrhages? Is there any sign of inflammation? In short, is there any evidence of pathology?

I believe this background information is important because, although section 1862(a)(7) of title XVIII excludes “routine physical checkups, eyeglasses, or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses,” there are many services of an optometrist being provided under this title which do not fall within this exclusion.

These optometric services can be provided by either a medical or osteopathic physician and surgeon, but because of the manner in which the law was drafted, these same services cannot be provided by an optometrist.

It is both a legal and moral responsibility that the examining optometrist be qualified to recognize pathology of the eye. He will not use drugs or surgery in the treatment of diseases of the eye, but the optometrists graduating from our 10 schools and colleges of optometry have been well trained to recognize these diseases so they can refer their patients so afflicted to appropriate health specialists in the same manner as does any general practitioner of medicine or osteopathy. Since millions of Americans, a majority of the public, seek optometrists regularly for vision care, much eye disease would go undetected if the optometrist were not trained to identify it.

STATE EXAMINES OPTOMETRISTS FOR PROFICIENCY

The National Board of Examiners in Optometry (whose annual examination of graduating optometrists is accepted for licensure requirements in a majority of the States) as well as each State board of optometry requires that each applicant demonstrate proficiency in the identification of both ocular and systemic diseases. Attachment E of my statement lists the subjects a typical examination covers.

OPTOMETRIC SERVICES ELIGIBLE FOR BENEFITS UNDER TITLE XVIII

Another example may assist you in understanding the problems we encounter under title XVIII. Color vision testing is not an eye examination for the purpose of prescribing, fitting, or changing eyeglasses. Some of these more complex testing procedures require 45 minutes of the practitioner's time for examination and evaluation.

Under the present law, the patient of a medical or osteopathic practitioner would be reimbursed for this examination, but the patient of an optometric practitioner could not be similarly reimbursed.

Other services eligible for benefits under title XVIII for which optometrists have been trained and are licensed in every State to perform include: visual field examinations, tonometry, ophthalmoscopy, artificial eye fitting, retinoscopy, biomicroscopy, eikonometry, orthoptics, pleoptics, and visual training. Descriptions of these services are provided in attachment A.

VISION PROBLEMS OF THE AGING

General systemic changes occur in almost everyone over age 40. To offer maximum benefit to the aging person, the optometrist must take these systemic changes, disorders, and malfunctions into consideration.

Among aging individuals there is often a lack of binocular control of the eyes so a sharp image cannot be maintained by both eyes at the same time without undue effort. The possibility of a pathological involvement of the neuromuscular system greatly increases as one grows older. Examination of the neuromuscular mechanism involves:

Fixation: Ability to move an eye in order to place and maintain the image upon the fovea.

Versions: Ability to move the eyes in the same direction.

Vergencies: Ability to move the eyes in opposite directions.

It is in the area of the visual neuromuscular system more than any other that the value of optometric examinations becomes evident.

In considering the problem of aging as related to vision, two pathologies of particular clinical importance should be noted—senile cataract and glaucoma.

The complaints found most frequently among patients suffering cataracts are “my vision blurs” and “I can’t see as well.” The degree of loss depends on the nature, extent, and position of the cataract.

When the optometrist identifies a cataract during the course of his examination, he refers the patient to an ophthalmologist because at present surgery is the only effective treatment for a cataract. Most eye surgeons prefer to delay operating until the cataract is “ripe.” During the waiting period the optometrist watches the patient carefully through further examinations and after surgery the optometrist may provide the patient with services to improve his vision.

There are few, if any ophthalmologists who will not accept the optometric diagnosis of cataract. It is unfortunate, however, but under the present law the patient of any general medical or osteopathic practitioner can be reimbursed for his discovery and referral of a cataract patient to an ophthalmologist, but the optometrist’s patient cannot be likewise reimbursed.

Most of you are familiar with the U.S. Public Health Service program which advises all Americans over age 40 to have periodic examinations for glaucoma. It is estimated that 1 to 2 percent of all patients over age 40 have glaucoma and the greatest incidence occurs in the 60–70 age group.

Of all ocular pathologies, glaucoma is most important to both the optometrist and ophthalmologist, because it is hardest to detect in early stages, and may eventually result in total blindness. The newest and latest instrument for the detection of glaucoma—the electronic tonometer—was developed by optometrists at our school in the University of California.

In acute glaucoma the patient may complain of such symptoms as pain or headache over the eye, visual disturbances or haziness, seeing halos around lights, and seeing flashes of light. As these symptoms relate to vision, the majority of people will seek care from their family optometrists. But here again, the patient of any medical doctor, regardless of specialty or lack of it, can be reimbursed for identifying

and referring the glaucoma, whereas the optometric patient cannot be so reimbursed.

MEDICARE BROCHURE

There is nothing in the Social Security Act which states that optometric services are excluded. Imagine the chagrin of optometrists throughout the country when millions of eligible medicare beneficiaries received a brochure from the Department of Health, Education, and Welfare which said they could not go to an optometrist for optometric services provided under the act and be reimbursed. This is not the exact language of the brochure, but this is exactly how it was interpreted.

AMENDMENT TO TITLE XVIII

Our problem might seem to be resolved by the simple incorporation of a section providing for payment of nonroutine optometric services as H.R. 5710 does for the services of podiatrists. Unfortunately, even this provision will not be adequate because the optometric patient will still be required to undergo unnecessary travel and inconvenience to seek out an osteopathic or medical practitioner so as to obtain a certification or recertification that the optometrist's services are or were required.

It is the belief of the American Optometric Association that the best solution would be an amendment to the section which defines a physician so the definition will include an optometrist. I proposed that such an amendment be inserted on page 55 of the bill before you, following line 18, to read:

PROVISION TO PROVIDE PAYMENT FOR OPTOMETRISTS' SERVICES UNDER THE PROGRAM OF SUPPLEMENTARY INSURANCE BENEFITS FOR THE AGED

SEC. 127. (a) Section 1861(r) of the Social Security Act is amended by inserting before the period at the end thereof the following:

"or (3) a doctor of optometry, but only with respect to functions which he is legally authorized to perform by the state in which he performs them."

VISION CARE UNDER TITLES OF SOCIAL SECURITY

Of the 19 titles which constitute the social security law, two have been repealed and eight of those remaining provide vision care which comes within the scope of the practice of optometry. Title X—Aid to the Blind—requires that, to be approved, a State plan must make available to the beneficiaries the services of an optometrist if they desire to utilize them.

Title XIX gives the State the option to provide vision care and requires that if it is provided, the beneficiaries must be free to choose between the services of an optometrist or a physician skilled in diseases of the eye.

Title XVIII is the one section which gives us greatest concern because of the very specific barrier it places between the optometrist and his patient. We feel confident that this was not the intent of Congress, but this is what has occurred.

HEW RECOGNIZES FREEDOM OF CHOICE PRINCIPLE

It seems ironic to the profession of optometry and must to the Department of Health, Education, and Welfare, that optometrists are recognized as essential health care practitioners, yet are unable to provide their services to Social Security Act beneficiaries.

I would like to quote from a letter dated August 1, 1966, written by Philip R. Lee, M.D., Assistant Secretary of HEW for Health and Scientific Affairs to the Honorable Henry Helstoski :

The profession of optometry is accepted by the Department as a legitimate and essential health profession which is performing highly useful functions in promoting solutions to the eye health of this nation.

In another part of the same letter Dr. Lee said :

The Department agrees that the American public should continue to have freedom of choice in the selection of a practitioner to care for vision problems.

All of the provisions of H.R. 5710 are of tremendous interest to optometric practitioners, either as potential beneficiaries or as providers of health services. While I do not want to take your time to comment on all of them, there are several items to which I must refer if I am to properly represent my profession before this committee.

VISION CARE OF CHILDREN

The American Optometric Association applauds HEW Secretary Gardner's desire to demonstrate new and effective ways for bringing comprehensive health care to areas suffering from lack of services.

We believe, however, that this committee could well point out to him that in the various title V grants which deal with comprehensive health care of needy preschool and school children, not one provides for the services of optometrists. The cause appears to be the policies and procedures manual distributed by HEW titled, "Grants for Comprehensive Health Services for Children and Youth," which contains a long list of the professional personnel to be used, including dentists, nurses, nutritionists, medical social workers, speech and hearing specialists, physical therapists, occupational therapists, and administrative officers—but not one word about optometrists.

Consequently, our members have spent months developing plans to assist these programs; they have tramped and knocked on doors for hours on end to no avail. They are told that since the law is silent regarding optometrists, as are the administrative regulations, optometrists' services are not covered by the term "comprehensive health care."

These disheartening experiences occurred despite the assurances made in a letter dated July 15, 1965, from then HEW Secretary Celebrezze to Senator Harrison Williams of New Jersey. The Secretary stated :

The section 532 relating to special project grants for low-income children of school and preschool age, as you indicate, does not refer explicitly to either eye care or to optometrists. It does require that projects must be comprehensive in nature. This would certainly include eye care. There is no doubt that the recipients of grants under section 532 of Title V would have authority to include the services of optometrists in providing eye care. And it would seem certain

that a great many, probably a substantial majority, of the eye examinations of children would be made by optometrists.

The letter is particularly interesting when related to the leading statistic quoted for title V during the last Congress that "10,500,000 schoolchildren need eyeglasses."

We are led to understand that in the new provisions of H.R. 5710 for early case finding and treatment of handicapping conditions of children that all children in low income or medically indigent families would be assured periodic screening, diagnostic services, and medical treatment—particularly in the preschool year.

Optometrists are keenly aware of the needs of these children. The "Volunteers for Vision" program under Project Headstart of the war on poverty is sponsored and carried out by members of the auxiliary to the American Optometric Association. We have seen hundreds of thousands of these children and identified a higher incidence of vision need among them than among the general population.

Most of these services were voluntary and unpaid and we were happy to provide them or to assist our local auxiliaries to see they were provided.

We know the truth in Secretary Gardner's statement:

We could dramatically reduce handicapping conditions among poor children * * * uncorrected vision problems by at least 40 percent.

But we notice with trepidation that the State agency now operating the crippled children's services program would be required "to organize the programs to screen children in low-income areas at specified ages and to provide diagnostic services and necessary medical treatment."

The clue to the problem is the term "medical treatment." The crippled children's program requires that only certified "medical" specialists shall provide, supervise, or administer services for crippled children. This language bars the child whose only health problem is visual from going directly to the optometrist for vision care. The term "medical treatment" should be changed to read "treatment by qualified health care practitioners" or be administered so as to appropriately include the services of optometrists.

In the very beginning of his statement on "Child Health" Secretary Gardner said:

Many preschool children who are poor and who need treatment for eye difficulties do not see a doctor; one million poor children who need glasses today do not have them.

We believe the Secretary's figures are conservative. It seems strange that the optometric profession whose services are so easy to obtain, so relatively inexpensive (compared with other health care costs), and so quick to produce tangible results, are bypassed to the detriment of the child.

NEED FOR EXPLORING GREATER UTILIZATION OF OPTOMETRISTS

I noted in his testimony before this committee Secretary Gardner said:

Now is the time to explore the use of physician assistants and other health personnel in ways that will multiply and expand the physician's services in order to bring good care to larger numbers of patients.

We hope the Secretary and this committee interpret his statement to mean that the Department will explore ways to more effectively utilize optometrists. We optometrists, 17,000 strong, can take a large part of the burden off the medical profession.

COMPENSATION AND TRAINING OF STATE PERSONNEL

One of the reasons why optometrists have not been used more effectively at the State level under federally funded programs can be traced to the omission of optometrists at administrative levels within State agencies.

Under section 224 of H.R. 5710, the Federal Government will pay 75 percent of the costs for compensation and training of State personnel. The section specifically states that the funds are for "professional medical personnel." No funds are made available for the compensation and training of other professional health care personnel. The unfortunate consequence to optometrists is that we can never expect to see an optometrist in one of these federally financed State positions.

FREEDOM OF SELECTION

You gentlemen will recall that during the 89th Congress, the bill which became Public Law 89-97 was amended by the Senate to include what became known as the "Freedom of Selection of Practitioner" amendment. This amendment stated:

Notwithstanding any other provisions of the Social Security Act, whenever payment is authorized for services which an optometrist is licensed to perform, the beneficiary shall have the freedom to obtain the services of either a physician skilled in diseases of the eye or an optometrist, whichever he may select.

We are not necessarily advocating that this language be incorporated in H.R. 5710 at this time, but merely point out that had the House accepted this amendment, many of the problems I have described would not have developed.

SUMMARY

In summary, gentlemen and ladies, optometrists submit that the public interest is not served by a restriction on direct access of patients to their services. The limited supply of vision-care manpower is even more severely limited for social security beneficiaries by the restrictive language of the law.

The unnecessary intermediate step of medical or osteopathic certification for optometric services creates a great inconvenience and hardship for the elderly patient who frequently must travel many miles to obtain such certification.

The effect of the present social security law is to limit the license lawfully granted to the optometrist by the State and to limit the freedom of the individual to select an optometrist for services authorized by the law.

To correct this inequity, we urge your favorable consideration of this single amendment which adds nothing to the law in terms of costs or benefits, but simply corrects a small wrinkle in this increasingly important legislation.

All we really ask is the opportunity to be of service. An example of the optometrists' deep interest in the vision problems of the aging is this volume which contains a collection of studies authored by a number of optometric authorities, the title "Vision of the Aging Patient," is considered an optometric reference for providing vision care to those in their golden years.

With your permission, Mr. Chairman, I will leave it with you for the committee's library.

Thank you for the opportunity to testify on behalf of the American Optometric Association. I will be happy to answer any questions members of the committee may have.

(The information referred to follows:)

AMENDMENT TO H.R. 5710

SEC. 127. (a) Section 1861(r) of the Social Security Act is amended by inserting before the period at the end thereof the following:

"or (3) a doctor of optometry, but only with respect to functions which is legally authorized to perform by the State in which he performs them."

ATTACHMENT A

SERVICES

Optometric services are broad in scope and include many services eligible for benefits under P.L. 89-97. A brief outline of some of the services which beneficiaries are eligible to receive from optometrists include:

Visual field examinations

1. *Screening (Roberts or Harrington-Flocks, Multiple Pattern Visual Field Test).*—For the detection of central field defects including scotomata and enlargement of normal blind spot. For detection of glaucoma, ocular pathology, and neurological disorders.

2. *Detailed Central Field Studies/Diagnostic Procedures.*—(a) *Tangent Screen:* To detect and record any central field defect, scotoma and/or enlargement of normal blind spot.

(b) *Stereo Campimeter:* Uses principles of binocular vision to permit sectional recording of small central field defects.

(c) *Amsler Grid:* A specialized test to detect very small/fine central field defects or areas of retinal dysfunction.

3. *Peripheral Field Studies.*—(a) *Perimeter:* To plot limits of visual fields for motion, form, and color. Abnormal fields may indicate neurological disorders, brain tumors, glaucoma, retinitis, etc.

(b) *Tangent Screen:* Similar studies on a larger scale.

(c) *Goldman Hemispheric Field Tester:* For motion, form, and color fields. Uses a uniformly illuminated hemispheric field for determining limits of peripheral field of vision and size of blind spot for white and colored light.

Tonometry

1. *Electronic Tonometry (Corneal).*—Extremely accurate method for determining intra-ocular pressure in glaucoma screening.

2. *Schiotz (Scleral).*—A glaucoma screening procedure.

3. *Wolff (Scleral).*—(Same as No. 2 above).

Ophthalmoscopy

For the detection and evaluation of signs and symptoms of ocular and systemic diseases (lenticular opacities, vitreous opacities ["floaters"]).

1. *Direct Method.*—(a) Monocular instrument generally used.

(b) Binocular instrument for special detailed studies of specific retinal areas.

2. *Indirect.*—Used when more convenient than direct viewing.

Space eikonometry

A diagnostic procedure using the space eikonometer to determine presence or absence of aniseikonia, a condition which results in perceptual distortion of objects viewed (i.e., walls, floors may appear to lean toward or away or be tilted, and rectangular shapes may appear trapezoidal). Aniseikonia is a contributing factor in some 3 to 5 per cent of patients who have vision complaints not relieved by ordinary spectacles.

Pupillography

A diagnostic procedure for determining status of neurological systems related to the eye by recording the response of the pupil to various conditions of light and other stimulation.

Artificial eyes

The fitting and supplying of artificial eyes is an optometric function included in provisions of the law.

Retinoscopy

Static and dynamic retinoscopy are used as objective measurements of the status of the eye in investigations of causes of amblyopia and aniseikonia. Findings are not used for determining of ordinary spectacle prescription in these cases.

Keratometry (ophthalmometry)

Corneal irregularities or degenerative corneal processes such as keratoconus (conical cornea) are detected, studied, and may be followed by means of this procedure.

Slit lamp biomicroscopy

Evaluation of the anterior segment of the eye (cornea, aqueous chamber, and crystalline lens) of slit lamp biomicroscope is essential for detecting corneal lesions, corneal dystrophy, iritis, lenticular opacities, and/or other changes.

Color vision testing

Detection of color vision deficiency is an important function often having a serious bearing on occupation. Tests used are pseudoisochromatic plates, Farnsworth lanterns, or similar color vision screening devices.

Evaluation of fusional status

Diplopia (double vision) may have sudden onset and be related to neurological disorders or indicative of a progressing tumor, or may be a result of injury from accidents.

Changes in ocular muscle functions and/or capability may be investigated using diagnostic procedures such as:

- A. Worth 4 Dot or Red Lens Test.
- B. Keystone or Other Stereographic Tests.
- C. Turville Infinity Balance Test.
- D. Stereo-Vectographs.
- E. Phorometric Tests.

Tests of accommodation, convergence, and binocular coordination at near and far points.

Orthoptics/pleoptics and visual training

When binocular coordination is poor, or fusion status is deficient, or poor reading performance is the result of either of the foregoing, visual rehabilitation may be accomplished through visual training procedures. This is also applicable to treatment of amblyopia and strabismus when indicated.

ATTACHMENT B

GLOSSARY

An *optometrist* is a Doctor of Optometry (O.D.) who is educated and licensed to examine the eyes and related structures to determine the presence of vision problems, eye diseases, or other abnormalities. He may prescribe and adapt lenses, contact lenses, or other optical aids and utilize vision training to preserve, restore, and enhance vision.

An ophthalmologist is a Doctor of Medicine (M.D.), who, following graduation from medical school, decides to specialize in the treatment of eye disorders by the use of drugs or surgery. He may also prescribe lenses and dispense them to his patients.

An optician is an artisan who grinds and polishes lenses and assembles them in frames to a doctor's prescription specifications.

An ophthalmic dispenser is a technician who guides in the selection of frames and may fit and adapt the fabricated prescription to the face.

Cataract is defined as "any opacity of the crystalline lens." Although there are other manifestations which occur in individuals of all ages, the "cataract" is primarily associated with senility.

Glaucoma is defined as "that pressure which the tissues of the particular eye in question are unable to withstand without damage to their structure or impairment of their function."

ATTACHMENT C

DEFINITION OF PHYSICIANS

1. From the California Workmen's Compensation Act :

Section 3209.3

Physicians include physicians, surgeon, optometrists, dentists, podiatrists, osteopathic and chiropractic practitioners licensed by California State law and within the scope of their practice as defined by California State law.

2. From the Rhode Island Workmen's Compensation Act :

Section 28-29-2 (c)

The word *physician* shall mean medical doctor, surgeon, dentist, chiropractor, osteopath, chiropodist and optometrist as the case may be.

3. From the U.S. Department of Defense implementation of the Military Medical Benefits Amendments of 1966 :

Army Regulation No. 40-121

Physician means a Doctor of Medicine or Doctor of Osteopathy who is legally qualified and licensed to practice medicine and surgery at the time and place the service is provided. For services authorized by this regulation, Doctors of Dental Surgery, Doctors of Dental Medicine, and Doctors of Surgical Chiropody, when acting within the scope of their licenses are deemed to be physicians.

ATTACHMENT D

OHIO STATE UNIVERSITY, SCHOOL OF OPTOMETRY CURRICULUM, 1966-67**Optometry****514 Practical Optometry P 4**

A. 3 cl., 1 3-hr. lab.

Prereq.: Optom. 4th yr. standing, Physics 412, and Math. 439.

Theory and techniques of keratometry, skiametry, objective and subjective tests of refraction, accommodation, and functions of the extra-ocular muscles. *Hebbard*.**515 Practical Optometry P 4**

W. 3 cl., 1 3-hr. lab.

Prereq.: 514.

Correlation and analysis of data. Systematic determination of the etiology of anomalies and sources of visual discomfort and inefficiency. Corrective procedures and prescription writing. *Hebbard*.**516 Practical Optometry P 4**

Sp. 3 cl., 1 3-hr. lab.

Prereq.: 515.

Ophthalmoscopy and examination of the external parts and the media of the eye. Case histories. Techniques of investigating special types of anomalies. Corrective procedures. *Hebbard*.**531 Mechanical Optics P 4**

Sp. 3 cl., 1 2-hr. lab.

Prereq.: Optom. 4th yr. standing, Physics 412 and, Math. 439.

Classification of ophthalmic lenses: physical characteristics, manufacture, and testing of optical glass and lenses; system of distribution and stocking; grinding and polishing; measuring refracting power. *Wülf*.**532 Mechanical Optics P 4**

W. 3 cl., 1 2-hr. lab.

Prereq.: 531.

Classification, description, manufacture, and distribution of frames and mountings. Laboratory practice in grinding, polishing, and mounting lenses, and repairing and reconstructing frames and mountings. *Wülf*.**533 Mechanical Optics P 4**

Sp. 3 cl., 1 2-hr. lab.

Prereq.: 532.

History and basic theory of ophthalmic lenses, facial measurements; writing specifications for lenses and frames to be assembled. *Wülf*.**541 Clinical Practice in Optometry P 5**

A, W, Sp, Su. 2 cl., 3 3-hr. lab.

Prereq.: 516.

Clinical practice in examining eyes and carrying out corrective procedures. The conference periods are devoted to the discussion of problems encountered during the clinic periods. *Hebbard, Wülf, Eskridge, Mote and Staff*.**542 Clinical Practice in Optometry P 5**

A, W, Sp, Su. 2 cl., 3 3-hr. lab.

Prereq.: 541.

Continuation of 541. *Hebbard, Wülf, Eskridge, Mote and Staff*.**543 Clinical Practice in Optometry P 5**

A, W, Sp, Su. 2 cl., 3 3-hr. lab.

Prereq.: 542.

Continuation of 542. *Hebbard, Wülf, Eskridge, Mote and Staff*.**545 Special Clinical Practice P 3-5**

A, W, Sp, Su. 1 cl., 2-4 3-hr. lab.

Prereq.: 516, concur. 541 and permission of instructor.

Repeatable to a maximum of 15 cr. hrs.

Clinical experience in specialized phases of optometric practice, (a) subnormal vision, (b) aniseikonia, (c) vision in schools and industry, (d) orthoptics, (e) contact lenses. *Hebbard, Wülf, Eskridge and Staff*.**555 Applied Pathology of the Eye P 4**

Sp. 3 cl., 1 2-hr. lab.

Prereq.: 516 and Anat. 603.

Advanced ophthalmoscopy, slit lamp microscopy, tonometry, and other methods of detecting pathological conditions. Systematic study of ocular diseases; artificial eyes and other prosthetic devices. *Hill*.**556 Applied Pathology of the Eye P 4**

A. 3 cl., 1 2-hr. lab.

Prereq.: 555.

Motor disturbances of eyes, paralytic strabismus, peripheral fixation anomalies, nystagmus, ptosis, ptosis crutches, anomalous accommodation and pupillary responses. *Eskridge*.**557 Applied Pathology of the Eye P 4**

W. 3 cl., 1 2-hr. lab.

Prereq.: 556.

Visual fields: scotometry; subnormal central vision involving pathology; telescopic lenses and aids of subnormal aids for subnormal vision; theory and practice in the use of contact lenses. *Hill*.**561† Optometric Economics and P 2**

Jurisprudence

W. 2 cl.

Prereq.: 516.

Historical background; legal status; practice building techniques; office accounting and general practice management; representative organization in optometry; professional ethics. *Hebbard*.**562† Visual Problems in Schools, P 2**

Industries, etc.

A. 2 cl.

Prereq.: 516.

Visual screening tests and survey methods for motorists, school children, industrial workers, etc; vision and vocational efficiency; visual aspects of job analyses and design. *Wülf*.**563† Civic and National Problems in P 2**

Eye Care

Sp. 2 cl.

Prereq.: 562.

Number, distribution, supply interrelationships, and roles of the various ophthalmic groups; prevalence of visual anomalies; problems and care of the blind and near blind. *Hebbard*.**601 Advanced Clinical Practice in P 5**

Optometry

A. 2 cl., 3 3-hr. lab.

Prereq.: Optom. 4th yr. standing and 516.

Advanced clinical practice. The conference periods are devoted to the discussion of problems and cases encountered during the clinic periods. *Wülf, Eskridge and Staff*.**602 Advanced Clinical Practice in P 5**

Optometry

W. 2 cl., 3 3-hr. lab.

Prereq.: Optom. 4th yr. standing and 601.

Continuation of 601. *Wülf, Eskridge and Staff*.**603 Advanced Clinical Practice in P 5**

Optometry

Sp. 2 cl., 3 3-hr. lab.

Prereq.: Optom. 4th yr. standing and 602.

Continuation of 602. *Wülf, Eskridge and Staff*.

- 651 Subnormal Vision** P 4
Sp. 3 cl., 1 2-hr. lab.
Prereq.: Optom. 3rd yr. standing and 516.
 Etiology of subnormal vision; measurement of loss of central acuity and other visual functions; design of optical devices for the aid of the partially sighted. *Eskridge.*
- 652 Aniseikonia** P 4
W. 3 cl., 1 2-hr. lab.
Prereq.: Optom. 3rd yr. standing and 516.
 Clinical methods of testing and measuring aniseikonia; etiology of aniseikonia; effects associated with uncorrected aniseikonia; design of lenses for aniseikonia. *Fugate, Albright.*
- 653 Contact Lenses** P 4
A. 3 cl., 1 2-hr. lab.
Prereq.: Optom. 3rd yr. standing and 516.
 Theory and practice in the use of contact lenses; artificial eyes; ptosis crutches and other prosthetic devices. *Bailey.*
- 660 Ophthalmic Pathology** P 5
Sp. 3 cl., 6 lab. hrs.
Prereq.: Optom. 4th yr. standing, 650.
 Gross and microscopic pathology of the eye, including diseases of the conjunctiva, orbital cavity and pertinent pathology of the central nervous system. *Hill.*
- ### Physiological Optics
- 611 Introduction to Physiological Optics** U G 5
Sp. 4 cl., 1 2-hr. lab.
Prereq.: Physics 505 and Anat. 608.
Not for grad. credit to students majoring in Physiol. Opt.
 The eye as an optical instrument; the refracting mechanism; the mechanism of accommodation and pupillary contraction; blur of the retinal image; stray light in the eye. *King.*
- 612 Introduction to Physiological Optics** U G 5
A. 4 cl., 1 2-hr. lab.
Prereq.: 611.
Not for grad. credit to students majoring in Physiol. Opt.
 The motility of the eye; the structure and innervation of the extra-ocular muscles, the center of rotation and analysis and description of eye movements. *Eskridge.*
- 613 Intermediate Physiological Optics** U G 5
W. 4 cl., 1 2-hr. lab.
Prereq.: 612.
 Monocular sensory mechanisms of vision; analysis and specification of visual stimuli; photoreception and retino-cortical transmission; adaptation of photoreceptors; flicker; brightness discrimination; and color-vision. *King.*
- 614 Intermediate Physiological Optics** U G 3
A. 3 cl.
Prereq.: 612.
 Circulation and metabolism of the eye; intra-ocular pressure; lacrimal system; movements and functions of the eyelids. *Hill.*
- 615† Intermediate Physiological Optics** U G 5
Sp. 4 cl., 1 2-hr. lab.
Prereq.: 613.
 Binocular integration of hue and brightness; retinal correspondence; visual perception of figure-ground relations, light, color, illumination, size, shape, direction, distance, and motion. *Fry.*
- 620 Measurement and Specification of Visual Stimuli** P G 4
W. 3 cl., 1 2-hr. lab.
Prereq.: Optom. 2nd yr. standing and 611.
Not for grad. credit to students majoring in Physiol. Opt.
 Light sources; diffusely transmitting and reflecting surfaces and scattering of light by a medium; principles of photometry and colorimetry as applied to visual stimuli. *Miller.*
- 701 Minor Problems in Physiological Optics** U G 1-15
A, W, Sp, Su.
Prereq.: Permission of department chairman.
 Repeatable.
 A properly qualified student may perform a minor investigation or add to his knowledge and technique. *Staff.*
- 715 Intermediate Physiological Optics** P G 5
W. 4 cl., 1 2-hr. lab.
Prereq.: Optom. 2nd yr. standing and 613.
 Projection of visual impressions; the horopter, retinal correspondence; binocular integration of hue and brilliance. *Eskridge.*
- 716 Intermediate Physiological Optics** P G 5
A. 3 cl., 1 2-hr. lab.
Prereq.: Optom. 3rd yr. standing and 732.
 Visual perception of color, illumination, figure-ground relations, size, shape, direction, distance, motion, time and complex patterns. *Fry and Miller.*
- 730 Principles of Lighting** P G 5
A. 4 cl., 1 2-hr. lab.
Prereq.: Optom. 4th yr. standing and 715.
 The effect of the distribution of light in a given environment upon efficiency, comfort and safety; selection and arrangement of sources and light control. *Fry.*
- 731 Vision in Industry** P G 5
W. 5 cl.
Prereq.: Optom. 4th yr. standing and 716.
 Visual testing in industry; relation of vision to performing a task; visual requirements for licenses; eye hazards and protection; compensation for loss of vision. *Fry.*
- 732 Vision in Schools** P G 5
Sp. 3 cl., 6 hr. lab.
Prereq.: Optom. 4th yr. standing and 716.
 Visual survey methods; the prevalence of visual anomalies and eye diseases in children; basic visual skills required in school and methods for their improvement. *Fry.*
- 801 Advanced Physiological Optics** G 5
A. 3 cl., 2 2-hr. lab.
Prereq.: 613.
 The ocular image-forming mechanism; accommodation and pupil contraction, aberrations, stray light; entoptic phenomena; shape, size, distortion; retinal illuminance and blur.
- 802 Advanced Physiological Optics** G 5
W. 3 cl., 2 2-hr. lab.
Prereq.: 801.
 Fixation disparity; photochemistry and electrophysiology of photoreceptors; luminosity; color-mixture; retinal-cortical transmission; simultaneous contrast; visibility; adaptation; after images. *Fry.*
- 803 Advanced Physiological Optics** G 5
Sp. 3 cl., 2 2-hr. lab.
Prereq.: 802.
 Binocular integration of hue and brilliance, fusional movements fixation, retinal correspondence, visual perception of figure-ground relations, light, color, illumination, size, shape, direction, distance, and motion. *Fry.*
- 950 Research in Physiological Optics** G Arr.
A, W, Sp, Su.
 Research for thesis or dissertation purposes only.

Anatomy

- 513 Comparative Vertebrate Anatomy** U 6
A, W, Sp, Su. 3 cl., 3 2-hr. labs.
Prereq.: Biol. 403 and Zool. 404.

The basic plan of vertebrates with emphasis on the dogfish shark and on phylogeny leading to the mammals. *Julman.*

- 607 General Histology** U G 6
W. 3 cl., 3 2-hr. labs.
Prereq.: 504 or 513 or equio.

Not open to pre-dental or pre-medical students.

A detailed study of the tissues, and a general survey of the microscopic structure of the various organs. *Wimmer.*

- 608 The Eye** U G 5
Sp. 2 cl., 2 3-hr. labs.
Prereq.: 607 and permission of instructor.

Human gross anatomy of the head and neck with special emphasis on the eye and orbit. Histology and embryology of the eye and associated structures.

Biology

- 402 Principles of Biology** U 5
A, W, Sp, Su. 3 cl., 2 1-hr. labs.
Not open to students with credit for Zool. 400.

A study of biological principles common to all living things: protoplasm, cells, development, organization, coordination, genetics, homeostasis, ecology, evolution and systematics. *Brockway, Koob, Menefee and Stag.*

Chemistry

- 411 General Chemistry** U 5
A, W, Sp, Su. 3 cl., 4 lab. hrs.
Prereq.: One unit of high school chem., and eligibility to enroll in Math. 439.

Not open to students with credit for 404.

A general course in fundamental chemical principles (411), the chemistry of the most important metals and non-metals (412), and qualitative analysis dealing with the separation and identification of the cations and anions (413). *General Chem. Staff and Assistants.*

- 412 General Chemistry** U 5
A, W, Sp, Su. 3 cl., 4 lab. hrs.
Prereq.: 411.

Not open to students with credit for 405 or 408.

Continuation of 411.

- 413 General Chemistry** U 5
A, W, Sp, Su. 3 cl., 6 lab. hrs.
Prereq.: 412.

Not open to students with credit for 406 or 409.

Continuation of 412.

- 551 Organic Chemistry** U 5
A, Sp. 3 cl., 6 lab. hrs.
Prereq.: 406, 409, or 413, or equio.

Not open to students with credit for 451.

A general introductory course in organic chemistry, including laboratory preparations, arranged for students preparing for dentistry, optometry, veterinary medicine, medical technology, and pharmacy. *Henne and Assistants.*

- 552 Organic Chemistry** U 5
W, Su. 3 cl., 6 lab. hrs.
Prereq.: 551.

Not open to students with credit for 452.

Continuation of 551. *Henne and Assistants.*

Mathematics

- 439 Algebra and Trigonometry** U 5
A, W, Sp, Su. 5 cl.
Prereq.: 412 or satisfactory score on OSU Math. Test.

Not open for credit to students having credit for 416 or Math. courses with 416 as prerequisite.

Inequalities, functions, graphs, exponential and logarithmic and trigonometric functions and their graphs, complex numbers, inverse functions.

- 440 Calculus and Analytic Geometry** U 5
A, W, Sp, Su. 5 cl.
Prereq.: 439 or Level I Placement on OSU Math. Test.

Not open to students with credit for 418.

Lines, slopes, derivatives, limits differentiation, rules, mean-value theorem, applications of derivatives to: curve sketching, maxima and minima, linear motion, related rates, approximations, conics.

Microbiology

- 607 General Microbiology** U G 5
A, W, Sp, Su. 3 cl., 2 3-hr. lab.
May not be taken concur. with 506.

Not open to students with credit for 550.

The characteristics of microorganisms and their applications in everyday processes; experience in isolating and identifying bacteria. *Randles, Frea, and Pfister.*

- 622 Principles of Infection and Resistance** U G 5
A, W, Sp, Su. 3 cl., 2 2-hr. labs.
Prereq.: 607 or equio.

A study of host-parasite relationships, with emphasis on pathogenicity and immunity. *Dodd, Chorpennig.*

Pathology

- 650 Pathology** U 5
A. 3 cl., 6 lab. hrs.
Prereq.: Optom. 4th yr. standing, Chem. 551-553;

Physiol. 601-602; Anat. 607-608.

General pathology including the etiology of infectious disease, disturbances of nutrition, inflammation, and neoplasia, with special reference to the influence upon ophthalmic pathology; selected chapters of Special Pathology; histologic and gross demonstrations. *Buerger.*

Physics

- 411 General Physics: Mechanics and Heat** U 5
A, W, Sp, Su. 4 cl., 1 2-hr. lab.
Prereq.: Eligibility for Math. 439.

Gaines.

- 412 General Physics: Electricity, Magnetism, and Light** U 5
A, W, Sp, Su. 4 cl., 1 2-hr. lab.
Prereq.: 411.

Erickson.

- 413 General Physics: Modern Physics** U 5
A, W, Sp, Su. 4 cl., 1 2-hr. lab.
Prereq.: 412.

- 505 Intermediate Geometrical Optics** U 3
W. 3 cl.
Prereq.: 411-413-413 and Math. 440.

Not open to students with credit for 605.

Ray optics of thick lenses, mirrors, prisms, and their combination; apertures and aberrations. *Nielson.*

- 506 Intermediate Physical Optics U 3
 Sp. 3 cl.
Prereq.: 411-412-413 and Math. 440.
Not open to students with credit for 606.
 Wave theory of optical phenomena; applications. *Nielsen.*
- 535 Geometrical Optics Laboratory U 2
 W. 1 4-hr. lab.
Prereq. or concur.: 505 or 605.
Not open to students with credit for 635.
 Selected experiments in geometrical optics. *Zamstein.*
- 536 Physical Optics Laboratory U 2
 Sp. 1 4-hr. lab.
Prereq. or concur.: 506 or 606.
Not open to students with credit for 636.
 Selected experiments in physical optics. *Zamstein.*

Zoology

- 404 General Zoology U 3
 A, W, Sp, Su. 3 cl., 3 1-hr. lab.
Prereq.: 400 or Biol. 403.
Not open to students with credit for 401 or 402.
 A study of the variety of animals with emphasis on organ systems and their functions, the interrelationships with each other, space and time. *Haub and Assistant.*

Physiology

- 601 Advanced Mammalian Physiology U G 5
 A. 4 cl., 1 lab.
Prereq.: Inorganic and Organic Chem., Physics 411, 412, 413 or equiv. and 1 year Biol. So. or permission of department chairman.
 Advanced physiology of muscle, nerve, central nervous system, special senses, digestion, and metabolism.
- 602 Advanced Mammalian Physiology U G 5
 W. 4 cl., 1 lab.
Prereq.: Inorganic and Organic Chem., Physics 411, 412, 413 or equiv. and 1 year Biol. So. or permission of department chairman.
Not for graduate credit to students majoring in Physiol.
 Advanced physiology of body fluids and excretion, circulation, respiration, body temperature regulation, and endocrines.

Psychology

- 505 General Psychology: Motivation and Action U 3
 A, W. 3 cl.
Prereq.: 3rd yr. standing and/or concur. 508.
 A behavioristic presentation of experimental work on learning and motivation. *Enckson, Miles.*
- 506 General Psychology: Learning and Thinking U 3
 W, Sp. 3 cl.
Prereq.: 3rd yr. standing and 505.
 The principles developed in 505 are extended to complex human behavior, especially verbal. *Johnson.*
- 623 Engineering Psychology U G 3
 A, Sp. 3 cl.
Prereq.: 504 or 508 or equiv., and 15 cr. hrs. in Psychol. or 5 cr. hrs. in Psychol. and 9 cr. hrs. in engineering courses on time and motion study, quality control, or machine design.
 Application of methods and techniques from experimental psychology to problems of equipment design for human use; the design, operation and management of man-machine systems. *Briggs, Goldstein.*

ATTACHMENT E

STATE BOARD EXAMINATIONS

After graduation from optometry school, the optometrist must take a State Board examination in the state in which he intends to practice. These examinations are administered by state boards of examiners in optometry. The typical examination covers the following subjects:

1. Ocular Anatomy.
2. Ocular Pathology.
3. Practical Optometry.
4. Theoretical Optometry.
5. Physical and Geometrical Optics.
6. Physiological Optics.
7. Physiology.
8. Optometrical Mechanics.
9. A Clinical Examination.

At their discretion thirty-four state boards grant licenses by reciprocity. Twenty-eight accept success on a uniform examination given by The National Board of Examiners in Optometry as a substitute for their own written examinations. The National Board of Examination consists of three sections. Part I encompasses Visual Science I, Theoretical Optics, and Anatomy of the Eye; Part II consists of Visual Science II, Theory and Methods of Optometry, Ophthalmic Optics, Diseases of the Eye, Social, Legal, Economic and Professional Aspects; and Part III is a practical examination in Clinical and professional Skill and Judgment.

ATTACHMENT F

BILLS TO AMEND TITLE XVIII OF THE SOCIAL SECURITY ACT TO PROVIDE PAYMENT FOR OPTOMETRISTS' SERVICES UNDER THE PROGRAM OF SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AS OF MARCH 8, 1967

- H.R. 216: William H. Bates (R.-Mass.).
 H.R. 719: Craig Hosmer (R.-Calif.).
 H.R. 737: Richard Ichord (D.-Mo.).
 H.R. 1261: B. F. Sisk (D.-Calif.).
 H.R. 1417: James B. Utt (R.-Calif.).
 H.R. 1465: Louis C. Wyman (R.-N.H.).
 H.R. 2141: Edward R. Roybal (D.-Calif.).
 H.R. 2302: Frank M. Clark (D.-Pa.).
 H.R. 2587: V. W. Thomson (R.-Wisc.).
 H.R. 3292: Don Edwards (D.-Calif.).
 H.R. 4104: James C. Corman (D.-Calif.).
 H.R. 4123: John J. McFall (D.-Calif.).
 H.R. 4243: W. R. Hull, Jr. (D.-Mo.).
 H.R. 4873: H. T. Johnson (D.-Calif.).
 H.R. 5621: Chet Holifield (D.-Calif.).
 H.R. 5885: J. M. McDade (R.-Pa.).
 H.R. 5889: T. P. O'Neill, Jr. (D.-Mass.).
 H.R. 6366: Henry Helstoski (D.-N.J.).
 H.R. 6789: Don Fuqua (D.-Fla.).
 H.R. 6807: James J. Howard (D.-N.J.).
 H.R. 6808: Charles S. Joelson (D.-N.J.).
 H.R. 6826: C. M. Teague (R.-Calif.).
 H.R. 6903: Donald D. Clancy (R.-Ohio).

ATTACHMENT G

POINTS CONSIDERED BY OPTOMETRISTS TO BE ESSENTIAL IN ANY ARRANGEMENTS FOR PROVISIONS OF VISION SERVICES

(By the Committee on Public Health and Optometric Care, American Optometric Association, November 21, 1966)

1. That they be allowed to join with others to serve the health needs of all our people.

2. That they be permitted to provide the highest quality and broadest scope of vision services to all the people.
3. That his dignity and code of ethics be respected.
4. That he be subject only to the judgment of his peers in his professional activities.
5. That he have freedom of professional judgment within his field of competence.
6. That he have reasonable remuneration commensurate with his education and professional service.
7. That he have opportunity to enhance his knowledge and skills through continuing education.
8. That he participate in the planning process for his own and his colleagues' services.

Mr. BURKE (presiding). Thank you, Dr. Chapman. Are there any questions?

Thank you, Doctor. We appreciate your appearance.

Dr. CHAPMAN. Thank you.

(The following documents were subsequently received:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
OFFICE OF THE COMMISSIONER,
Baltimore, Md., April 27, 1967.

Mr. JOHN M. MARTIN, Jr.,
*Assistant Chief Counsel, Committee on Ways and Means,
House of Representatives, Washington, D.C.*

DEAR MR. MARTIN: As you requested, I am enclosing a statement about the coverage of eye care under the health insurance program of title XVIII of the Social Security Act. I am also sending you a copy of a position paper issued by the American Optometric Association which, among other things, requests an amendment to the law that would bring optometrists within the definition of a "physician." A similar statement has been sent to Mr. Ullman.

As you know, payment cannot be made under the medicare program for routine checkups, or for eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses. Payment can be made, however, for services furnished by physicians in connection with the diagnosis and treatment of eye diseases or injuries. Thus, treatment by an ophthalmologist (or any other physician) of a disease of the eye is covered under the program, but the charges he may make for an eye examination to determine the need for eyeglasses or charges for prescribing and fitting eyeglasses are not covered. The enclosed statement sets out the policies that apply with respect to the exclusions.

Optometry is the clinical application of physiological optics (as opposed to the diagnosis and treatment of pathological eye conditions). As the American Optometric Association's statement indicates, an optometrist, in conducting an eye examination, may use some of the same techniques used by an ophthalmologist—visual field examinations, tonometry, ophthalmoscopy, and other evaluative procedures routinely used in connection with examinations for the purpose of detecting refractive errors and, where necessary, prescribing eyeglasses. It is true that an optometrist's professional training also includes instruction in the recognition of symptoms of eye diseases. However, the services of optometrists do not include the medical diagnosis or treatment of pathological eye conditions. When an optometrist detects or suspects the presence of pathology, he is under a professional obligation to refer the patient to a physician for medical diagnosis and treatment. An optometrist's services rendered in connection with the usual determination of the need for eyeglasses or in the usual determination of the type of glasses to be provided are excluded from coverage whether provided by a medical doctor or an optometrist. On the other hand, the services rendered by ophthalmologists which are covered under the program—those not related to eyeglasses—are usually not performed by optometrists.

If coverage were provided under the program for an optometrist's services in those cases in which there is some recognition of disease symptoms and subsequent referral of the patient to a physician, a significant precedent would be established for extending similar coverage to the services of a large number of other types of nonphysician paramedical personnel. For example, physical and

occupational therapists, audiologists, speech pathologists, psychologists, and other types of practitioners may, in the course of providing their usual services, detect symptoms of disease and refer patients to physicians for a medical diagnosis and treatment. Moreover, to provide coverage for the services of nonphysician practitioners before a clear medical need for the services has been established by a physician would represent a basic shift in emphasis since the present law is based on the premise that the physician is to be the key figure in determining both the need for and the utilization of health services.

We can understand the concern expressed by the optometrists that with respect to the services they are legally authorized and competent to provide they be treated on an equal basis with medical doctors. However, we believe that present law does not violate this principle and that it is neither necessary nor desirable to amend the statute to include optometrists within the definition of the term "physician" in order to assure adherence to this principle. The services which optometrists are legally authorized and competent to perform are generally those services which are specifically excluded from coverage as eye examinations for the purpose of prescribing eyeglasses; where an ophthalmologist performs the same services for the purpose of prescribing eyeglasses they would also be excluded. However, the ophthalmologist is also a medical doctor with a recognized legal authorization and competence to perform a considerably broader range of eye care services covering the diagnosis and treatment of eye diseases and injuries. Thus, inclusion of ophthalmologists in the term "physician" is intended to give explicit recognition to the fact that ophthalmologists perform services outside of the special legal authorization and competency of optometrists.

In addition, as medical doctors, ophthalmologists bear along with all other physicians certain additional responsibilities under the medicare program which are related to their legal status and professional competence. Thus, the medicare program provides that the determination as to the need for medical services is a decision to be made by a medical doctor, i.e., a "physician" in the language of the statute, and that such services are to be provided either by the physician or in accordance with his authorization or prescription. (Also, as you know, physicians must serve on utilization review committees and assume the responsibility for rendering medical judgments on admissions, length of stay and the medical necessity for services furnished in an institutional setting.) To include optometrists within the term "physician" would, therefore, have the effect on one hand of extending to optometrists the right to receive reimbursement for their services or services that they might prescribe without the authorization of a medical doctor, and on the other hand of extending to optometrists certain functions and responsibilities which they cannot now perform and which would exceed their professional competence.

Sincerely yours,

ROBERT M. BALL,
Commissioner of Social Security.

* * *

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
OFFICE OF THE COMMISSIONER,
Baltimore, Md.

REPORT REGARDING THE COVERAGE OF EYE CARE UNDER THE HEALTH
INSURANCE PROGRAM

Background

Section 1862(a)(7) of the law excludes from coverage routine physical check-ups, eyeglasses, or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses without regard to whether these services are furnished by a physician or by another practitioner. The term "physician," as defined for medicare purposes, includes a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action. An ophthalmologist is a "physician" specializing in the diseases of the eye. Optometrists, however, are not included within the scope of the statutory definition of the term "physician," since they are not legally authorized to practice medicine and surgery.

Present policy

Since an ophthalmologist is a "physician," his medical services are covered in the same manner as the services of any other medical doctor. Likewise, the services he performs which come within the exclusions relating to routine physical examinations and examinations for the purpose of prescribing, fitting, or changing eyeglasses are not covered, just as they would not be covered if any other physician furnished such services.

When an ophthalmologist, or any other physician, furnishes eye care services to an eligible beneficiary, the program will cover the physician's services if the examination results in a pathological finding (other than refractive error) and/or treatment of an eye disease or injury. If no eye disease or injury is found, the physician's services rendered to the patient during that visit are excluded from coverage since the services would then come within the exclusions relating to routine physical checkups or examinations for the purpose of prescribing, fitting, or changing eyeglasses.

Discussion

Various alternatives were explored in attempting to arrive at an equitable and administratively feasible policy with regard to the exclusions. After extensive consultation with professional associations representing ophthalmologists and optometrists, specialists in the Public Health Service, and many insurance companies which presently administer similar provisions in their own health plans, consideration was narrowed down to essentially two basic approaches:

1. Separate the services furnished by an ophthalmologist during an examination of a patient into two component parts—(a) refractive-type services and (b) all other services relating to the diagnosis or treatment of an eye disease or injury. Exclude from coverage the refractive-type service performed by an ophthalmologist (or any other physician) during any given examination of a patient as services representing an "eye examination for the purpose of prescribing, fitting, or changing eyeglasses";

2. Treat all the services furnished during any given examination by the ophthalmologist (or any other physician) as covered or excluded in their entirety depending upon the findings made and/or treatment provided as a result of the examination. For example, when the physician finds no eye disease or injury, treat the entire examination as an excluded service since it will essentially represent either a "routine physical checkup" or "eye examination for the purpose of prescribing, fitting, or changing eyeglasses." On the other hand, where a disease or injury of the eye is diagnosed, treat the entire examination by the physician as a covered service.

After careful and extended deliberation, the second approach was adopted. Among the more compelling considerations for adopting this approach are the following: Ophthalmologists have pointed out that, from a professional and practical point of view, there is no distinction made by the ophthalmologist in the type of services performed, that there are many situations where refractive-type services furnished by an ophthalmologist are an essential part of the diagnostic steps required in order to ascertain or confirm the presence of a pathological condition, that ophthalmologists have never treated any portion of their charges as relating specifically to a refraction, and that with respect to any given visit there is essentially no distinction made in charges regardless of whether or not a refraction is performed.

Another practical consideration for adopting the second approach was the experience of the health insurance industry with this type of exclusion. The great majority of the insurance companies and Blue Shield plans which we have contacted and which administer eye care provisions similar to those contained in the medicare law use essentially the second approach in their own programs. Moreover, since beneficiaries and physicians have had considerably more experience with this method under private insurance plans, it can be expected that by using the same approach under medicare, beneficiary and physician understanding of the policy would be enhanced.

One additional significant consideration for adopting the "all or nothing" approach is that this approach would not create a situation which would be inequitable to optometrists since there would be no incentive for a beneficiary to go to an ophthalmologist for services which are in reality for the purpose of prescribing, fitting, or changing eyeglasses.

An optometrist is not a "physician" under the medicare law nor are optometric services listed among the other health services covered by the medical insurance program. Therefore, those services performed by independently practicing optometrists which are not included within the coverage provisions of the law or which are contained in the statutory exclusions are not reimbursable as covered expenses under the medical insurance program. Thus, optometrists' services performed in connection with prescribing, fitting, or changing eyeglasses are excluded from coverage. However, optometrists' services performed in connection with furnishing prosthetic lenses prescribed for the beneficiary by a physician are covered as are the prosthetic lenses themselves. (While eyeglasses are specifically excluded from coverage, a separate provision of the law covers prosthetic devices—other than dental—which replace all or part of an internal body organ. Thus, "eyeglasses" which replace an internal body organ (the lens of the eye), as for example after cataract surgery, are covered as *prosthetic lenses*.)

ROBERT M. BALL,
Commissioner of Social Security.

* * *

A POSITION STATEMENT BY THE AMERICAN OPTOMETRIC ASSOCIATION'S DEPARTMENT OF NATIONAL AFFAIRS CONCERNING TITLE XVIII OF PUBLIC LAW 89-97

The Department of National Affairs is gravely concerned that the traditional freedom of the optometric patient to independently select a doctor of optometry for optometric services is being eroded by Title XVIII of Public Law 89-97, better known as "Medicare". *The effect of this law is far reaching and has an injurious impact upon the traditional pattern of providing optometric services to the people of America.*

Although the law specifically excludes from coverage "... routine physical checkups, eyeglasses, or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses . . ." (section 1862(a)(7)), and this exclusion is applicable whether such services are performed by an ophthalmologist or by an optometrist, many of the services of an optometrist which do not come within this statutory exclusion are being provided under Medicare. Because of the manner in which the law was drafted, the doctor of optometry is prohibited from providing covered services to his patient, but the medical or osteopathic doctor is encouraged to provide them.

Part "B" of Medicare permits doctors of medicine and osteopathy to perform the following types of services, for which optometrists have been trained, and are licensed to perform—

- (1) Visual field examinations,
- (2) Tonometry,
- (3) Ophthalmoscopy,
- (4) Artificial eye fitting,
- (5) Retinoscopy,
- (6) Slit lamp biomicroscopy,
- (7) Color vision testing,
- (8) Evaluation of fusional status,
- (9) Orthoptics/pleoptics and visual training,
- (10) Space eikonometry,
- (11) Certification of need for aphakic correction or replacements,
- (12) Developmental examination of retarded children,

and other investigations that are for the purpose of determining whether or not a patient has an abnormal ocular or systemic condition that is revealed by one or more of the many eye examination procedures.

THE OPTOMETRIST IS EDUCATED TO DETECT PATHOLOGY

Optometric education and public policy places upon the optometrist the right and responsibility to detect the presence of pathology. In his painstaking probe for any pathology or abnormality of the eye, or of the neuromuscular system which supports visual function, he uses the ophthalmoscope, the slit lamp, the exophthalmometer, the transilluminator, and a variety of additional instruments, the procedures for which Medicare reimburses the patients.

THE OPTOMETRIST IS UNIFORMLY LICENSED AND HIS EDUCATION ACCREDITED

Title XVIII compels the beneficiary to seek services from only three kinds of practitioners, the medical, osteopathic and dental. There are only four disciplines in the United States which independently examine, prescribe and correct one or more of the health problems of human beings; who are licensed by every state, and whose educational accreditation is accepted by the U.S. Office of Education. These are medicine, dentistry, optometry, and podiatry. Yet, Title XVIII of Public Law 89-97 restricts the beneficiary to only two of the four disciplines, medicine and dentistry. The significance of this limitation is clear. *It severely interferes with the public's method of obtaining health services from optometrists. Services which are regularly provided by optometrists for their patients can only be obtained from doctors of medicine or osteopathy.*

CONGRESS INTENDED FREE CHOICE BY PATIENT

It was the intent of Congress that free choice of the patient should be guaranteed. Section 1802 states: "Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency or person undertakes to provide him such services."

Section 1802 of Medicare is violated for the optometric patient by the requirement of the law that only a physician can provide or certify as to the need for the provision of services to the beneficiary. For the purposes of Title XVIII: "The term 'physician' when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he performs such function or action (including a physician within the means of section 1101(a)(7) or (2) a doctor of dentistry or of dental or oral surgery who is legally authorized to practice dentistry by the state in which he performs such function but only with respect to (A) surgery related to the jaw or any structure contiguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone." (Section 1861(r))

These provisions of the law which interfere with established relationships between patients and optometrists or which impair the freedom and right of those covered by the Act to obtain authorized health care services from doctors of optometry would be corrected by including the optometrist within the definition of a "physician" as that term is defined in Section 1861(r).

THE OPTOMETRIC PATIENT IS COMPELLED TO SEE A PHYSICIAN FIRST

The administrative interpretation of the law provides that an optometrist will be paid for his services only if some medical doctor has ordered or approved the services of the optometrist.

Robert M. Ball, Commissioner of Social Security, in a letter to the Washington Office of the American Optometric Association stated "* * * the services which an optometrist may perform in providing prosthetic lens would be covered service under the law (for example, where the lens of the eye has been removed as in cataract surgery and the optometrist makes the refraction for the prosthetic lenses). As you know, prosthetic devices which replace all or part of an internal body organ are covered under a separate provision of the law (Section 1861(s)(8))."

In a separate letter to the Washington Office four days later, Dr. Howard L. Bost, Acting Director of the Social Security Bureau of Health Insurance, reiterated the language contained in the letter of his Commissioner and then added: "Where a physician determines that there is a need for a prosthetic lens under this condition, payment can be made under the supplementary medical insurance program for the covered prosthetic lens regardless of whether it is furnished by an ophthalmologist, an optometrist, or an optician."

OPHTHALMOLOGIST CAN BE PAID FOR OPTOMETRIC SERVICES
BUT OPTOMETRIST—NO

Of the three occupations listed by Mr. Bost, only the ophthalmologist is defined as a "physician" for purposes of the law. The ophthalmologist is free to provide the optometric services authorized under the Act without hindrance whereas

the doctor of optometry, who is not defined by the Law as a "physician" must require his patient to undergo a "physician's" determination as to need before he can proceed in providing his services. Even then, he is limited to those services which relate solely to the provision of an aphakic lens or lenses.

It would appear that if the patient of an optometrist can be reimbursed for his optometrists services in connection with the provision of aphakic lenses that he should also be able to obtain reimbursement for other authorized optometric services, providing of course, that a "physician" had previously determined the need. The Social Security Administration states that the patient cannot be so reimbursed because of the limiting language of Section 1861(s) which defines which medical and other health services can legally be provided. Section 1861(s) lists, as the first two services which can be provided:

"(1) physician's services;

"(2) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations be self-administered) furnished as in incident to a 'physician's' professional services, of kinds which are commonly furnished in physician's offices and are commonly either rendered without charge or included in the physician's bills and hospital services (including drugs and biologicals which cannot as determined in accordance with regulations, be self-administered) incident to physician's services rendered to outpatients * * *"

According to the Social Security Administration, medical or osteopathic practitioners can be reimbursed on claims for all services, except those expressly excluded by law (and, therefore, can provide those optometric services which are authorized), because they are defined as "physician". Optometrists cannot be reimbursed because they are not so defined.

LAW SAYS OPTOMETRY CAN ONLY BE AN INCIDENT TO A PHYSICIAN'S SERVICE

There is one exception, however. *The Administration can reimburse optometric patients for aphakic lenses, and the necessary services connected therewith, but only because they are "services and supplies * * * furnished as an incident to a physician's professional service."* Even with this loophole, the optometric patient cannot be reimbursed "unless a physician has determined the need."

It is no secret that in many instances, medical doctors will not authorize the health care services of an optometrist, and generally do not refer patients to optometrists. Although optometrists are licensed to render health care services for the eye in every state, the American Medical Association has regarded associations between medics and optometrists as being unethical. From the view of many, such conduct by medical doctors and by the American Medical Association restrains doctors of optometry in the practice of their profession.

The AOA Department of National Affairs believes that Congress, in adopting this legislation authorizing certain types of health care for the eyes, did not provide or intend to provide that medical doctors should have the right to determine for the patient whether an optometrist may render a health care service included within the Act's coverage and which the optometrist is qualified and licensed in every state, district and territory to perform.

ADMINISTRATION AGREES THAT PATIENT SHOULD HAVE FREEDOM

The law needs a provision which accords to the patient the freedom to seek those optometric services which are authorized by the Act from an optometrist without the prior or subsequent approval of a medical doctor. Moreover, *the administrative regulation should make it clear that optometrists have a status coordinate to that of doctors of medicine with respect to those health care services which optometrists have been licensed to render.* This accords with administrative policy as contained in a letter of August 1, 1966 to Congressman Helstoski of New Jersey from Dr. Philip R. Lee, HEW's Assistant Secretary for Health and Scientific Affairs.

Doctor Lee wrote:

"Since 1950 the provisions of Title X of the Social Security Act authorizing grants to states for aid to the blind have required that state plans for this program 'provide that in determining whether an individual is blind, there shall be an examination by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may elect.' The Public Welfare Amendments of

1962 established Title XVI of the Social Security Act authorizing grants to states for aid to the aged, blind or disabled, or for such aid and medical assistance for the aged. Identical language with that contained in Title X is included in this new title. The Social Security Amendments of 1965 included a new Title XIX of the Social Security Act authorizing grants to states for medical assistance programs. Section 1905, which defines the term 'medical assistance' includes the language 'eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select.'

"Thus, in the determination of blindness as a factor of eligibility for public assistance payments and in the prescription of eyeglasses under the new medical assistance programs, the Federal Law requires states to give an individual his free choice of an optometrist or a doctor of medicine. While such a requirement does not exist with respect to other aspects of public welfare programs, the silence of the Federal statute in no way limits the freedom of states to use optometrists in such other ways as they may find appropriate.

"The Department agrees that the American public should continue to have freedom of choice in the selection of a practitioner to care for vision problems."

OPTOMETRISTS ARE QUALIFIED AND READILY AVAILABLE

Optometrists are legally and academically qualified in all states and territories to perform—with the exception of surgery and medication all of the vision and eye care services medical doctors are now performing under Medicare. Optometrists are performing more than 75% of the vision care services provided to the general population and, because there are some 17,000 of them, compared to less than 5,000 certified ophthalmologists, they are more readily available and more widely distributed. In addition, affording the beneficiary freedom whether to obtain health care authorized by the Act from an optometrist will avoid paperwork involved in securing medical approval or certification of the optometrist's services.

The inclusion of optometrists within the legal definition of "physician" is not new. Several state laws, such as that of California, include optometrists within the definition of physician for the purpose of the state's workman's compensation programs. The inclusion under the Medicare program of optometrists as "physicians solely for the purposes of Title XVIII, differs in no way from the similar purpose of Congress when it defined dentists as physicians for purposes of the Act.

It is unthinkable that the United States Congress would contemplate legislating any nationally qualified profession out of its universally accepted practice. Especially optometry, which is currently providing more than 500 commissioned officers for the military services, 100 of them recently drafted from essential and critically important civilian practices.

OPTOMETRIC SERVICES ARE INCLUDED BUT OPTOMETRISTS CUT OFF

It appears, however, that if the Act remains as it is, optometric services being included in the Act, but optometrists cut off from the provision of its covered services, that the livelihood of the more than 17,000 optometrists of the United States is seriously affected.

One of the serious weaknesses of Title XVIII is that when referring to "medical care" it deals with one health area only. The term "medical care" ignores the other respected health professions which independently serve the patient's health needs. The American Optometric Association believes that Congress intended to use the term "medical care" in its broadest sense so that the patient would be free to select not only the "institution, agency, or person qualified to participate under this title," but also the qualified health discipline most desired by the individual.

The omission of the optometrist as a provider of professional service is a drastic one, not only for the patient, who must break a life-long habit of going to his family optometrist for eye services, but because it places an additional burden on the nation's critically overworked ophthalmologists. Over 100 million Americans seek the services of optometrists and ophthalmologists. Millions more need optometric services but have not obtained them for one reason or another. The greatest demands and the greatest needs for these services are among persons sixty-five years of age or older, those for whom the Medicare program was in-

tended. This age group is also the group most inconvenienced when required to travel long distances to seek an ophthalmologist, when the optometrist's service is nearby and readily available.

TAX DOLLARS WERE PROVIDED TO TRAIN OPTOMETRISTS

Optometrists are members of the only profession requiring a minimum of six years of education at the university level, four years of which are devoted solely to studies of the eye and vision care. They are in the only profession licensed exclusively to serve the vision needs of the nation. To obtain such a license they are strictly examined by state boards appointed exclusively for that purpose by the governors of every state and territory of the Union. Among them will be graduates for which federal tax dollars were expended under the Health Professions Training Act to educate individuals who are not only competent to perform eye examinations and undertake corrections of the health problems found, but also to know when individual cases should be referred for medical or other professional attention.

TITLE XVIII REQUIRES CORRECTION

The definition of "physician" under section 1861(r) of Title XVIII should be amended by adding before the period at the end thereof the following: ", or (3) a doctor of optometry, but only with respect to functions which he is legally authorized to perform by the state in which he performs them."

There is no additional authorized cost to the taxpayer by the addition of this amendment nor is there any new benefit to be provided under the program because of it. The services authorized to be performed by optometrists already are in the law. It will assure freedom for the patient to select the discipline of his choice for a service, which if restricted to medical practitioners will limit its availability to a great proportion of the public, particularly in rural areas. Ophthalmologists need large hospitals, usually found in metropolitan areas, for their patients, and consequently establish practices nearby, whereas optometric practices are to be found in almost every small town and rural area of the nation.

The simple intent of the amendment is to remove the requirement that a medical or osteopathic doctor must certify that the services to be provided are necessary before an optometrist can be reimbursed for his authorized services.

In the event a correction to Title XVIII is not made soon, a grave injury will result to the traditional optometric patient relationship enjoyed by our senior citizens who need optometry's continued attention the most.

Mr. BURKE. The next witness is Dr. Simard. Dr. Simard, please come forward. Will you identify yourself for the record, Doctor, and also your associates.

STATEMENT OF DR. ERNEST E. SIMARD, PRESIDENT, COLLEGE OF AMERICAN PATHOLOGISTS, ACCOMPANIED BY DR. O. B. HUNTER, JR., PRESIDENT-ELECT AND OLIVER J. NEIBEL, JR., EXECUTIVE DIRECTOR

Dr. SIMARD. Mr. Chairman, I am Dr. Ernest E. Simard, of Salinas, Calif., president of the College of American Pathologists. Accompanying me are Dr. Oscar B. Hunger, Jr., of Washington, D.C., president-elect of the College of American Pathologists and Mr. Oliver J. Neibel, Jr., of Chicago, Ill., executive director and general counsel of the college.

The College of American Pathologists is a professional society of physicians representing approximately 5,000 doctors of medicine practicing the medical specialty of pathology in hospitals and medical schools, clinics, government, research, and private offices throughout the country.

I appear before you today representing these physicians in presenting their views on those aspects of H.R. 5710 which seek to amend title XVIII to establish a new part C which will include changes in the provisions for coverage of, and reimbursement for inpatient diagnostic X-ray and inpatient pathology services and all outpatient hospital services.

Pathologists are particularly concerned over the legislation now before you for consideration. Although inexorably a substantial number of physicians who are not pathologists or radiologists will be directly affected as to the method of their professional remuneration by enactment of the part C concept, the concern of pathologists over and above that of the rest of medicine lies in the fact that the professional services of pathologists rendered in hospitals are specifically included in the complementary part C program.

With the risk of taking many of you once again over a quite familiar path, I beg your indulgence while I briefly review the legislative history of the provisions relating to the reimbursement for the provision of pathology service to medicare beneficiaries.

—In both H.R. 1 and S. 1, 89th Congress, the professional services of pathologists, radiologists, anesthesiologists, and physiatrists were specifically included in definition of "inpatient hospital service" and "outpatient hospital service."

In passing H.R. 6675, 89th Congress, this committee of the House of Representatives removed this adverse discrimination against these doctors by treating physicians' professional services in these specialties in exactly the same way as other doctors' services were covered under part B of title XVIII.

Speaking quite frankly, pathologists would have preferred to have the total payment for their professional services placed in the voluntary insurance portion of title XVIII, and then for the pathologist to reimburse hospitals for the space, equipment, supplies, personnel, et cetera, furnished by the institution.

We genuinely believed then, and are of the current conviction, that this would have provided the maximum physician control over the medical services rendered to each patient.

However, the House of Representatives and the Congress chose in enacting Public Law 89-97, 89th Congress, to provide that the non-professional costs involved in the operation of the departments of pathology, radiology, anesthesiology, and psychiatry be reimbursable along with other hospital costs under part A of title XVIII.

The services of all physicians, including pathologists and the other so-called hospital-based specialists, would all be paid under the same part B of the law. This committee was particularly clear on this point in its report to the House on H.R. 6675 (H. Rept. 213, 89th Cong., first sess., 24 (1965)) :

Payments would not be made under the hospital insurance plan for the services of physicians, except services provided by interns and residents in training under approved teaching programs. Like other physicians' services, the services of radiologists, anesthesiologists, pathologists, and other physicians employed by the hospital or working through the hospital would be paid for under the voluntary supplementary plan; such services would not be covered under the hospital insurance plan. However, the services of the nonphysicians aiding such persons would be covered under the hospital insurance plan.

Unfortunately the administrative implementation of Public Law 89-97 has not chosen to follow what we believe to be the clear mandate of the Congress. Beginning in January 1966, with the publication by the Secretary of the Department of Health, Education, and Welfare of a series of eight principles entitled "Reimbursement Under Medicare for Service of Hospital-Based Physicians"; continuing in June 1966 with proposed rulemaking relating to the principles of reimbursement of hospital-based physicians; and ending with the publication on October 18, 1966, of Part 405, Subpart D: Principles of Reimbursement for Providing Costs and for Services by Hospital-Based Physicians, the Department of HEW, despite repeated objections from the college, the AMA and others, has interjected into the regulations an illusory principle which provides, in essence, that the only physicians' services reimbursable under part B are identifiable services requiring performance by a physician in person on behalf of a specific individual patient.

This administrative principle as applicable to pathologists, excludes from payment under part B, a large portion of the pathologists' professional practice of medicine. All of the time of a physician practicing pathology spent in setting standards, establishing controls, and otherwise supervising the clinical laboratory for which he is individually and directly responsible must be remunerated through the hospital under part A of the law.

This is true even though HEW admits that this service requires a pathologist's "professional expertise." In practical effect, this administrative requirement effectively prevents the hospital-based pathologist, except in those instances where he personally has reviewed the specimen or file of the individual, from separating his physician's fees from hospital charges and billing the patient or his carrier for such medical fees.

This, we submit, was not the desire of the Congress and has caused a disruption of existing patterns between doctors and hospitals and has been in large part responsible for the administrative quagmire which has caused HEW to seek the enactment of part C.

The pathologists of this country, as represented by the college, are currently being forced to practice their profession and to negotiate their relationships with hospitals within a regulatory framework promulgated by the Department of Health, Education, and Welfare which has resulted in a situation varying from mild confusion in some areas to utter chaos in others. This situation cries for correction.

The proposed part C will in large measure correct the administrative deficiencies of Public Law 89-97 which we find in the law in action. To many, including the college, it seems unnecessarily drastic to urge legislative correction of administrative error. However, the Department of Health, Education, and Welfare informs us that in their view of the law an administrative correction of the confused situation in which we are all embroiled is impossible. The college has exhausted its administrative remedies and, therefore, short of involved and protracted litigation, finds itself in a situation where the only alternative appears to lie in legislative action.

If this view of the administration is correct, then the college would urge the principles embodied in the part C concept be recommended by this committee to the Congress for its adoption.

In making such a recommendation we have some serious misgivings. The elimination of deductible and coinsurance requirements for hospital inpatients cannot help but cause greater utilization and result in higher costs for the program.

We also have great concern over the advisability of paying for any physicians' services from part A trust funds as this tends to segregate physicians thus compensated from the mainstream of medicine.

On the other hand, approval of the part C concept would allow pathologists complete freedom at the local level to work out their agreements with hospitals unfettered by an artificial administrative requirement which refuses to pay them as doctors unless they personally lay their hands on the patient or the specimen.

Furthermore, unlike the present situation, the part A fiscal intermediary would play no role in determining the mode or reasonableness of physicians' arrangements with hospitals. In addition, the outpatient services in hospitals would be subject to a uniform deductible and in parity with similar services performed in physicians' private offices.

This latter change could not help but to eliminate much patient confusion and more correctly classifies outpatient diagnostic services as physician services paid under part B of title XVIII.

Accordingly, on behalf of the College of American Pathologists I would urge that this committee give serious and thoughtful consideration to those section of H.R. 5710 which would create a new part C under title XVIII of the Social Security Act. It would appear to us that from the standpoint of the current law as it is being applied by the administration, this concept has considerable merit and would substantially alleviate much patient confusion regarding medicare and its benefits, in addition to its salutary effect on the freedom of pathologists to practice their profession with a minimum of unnecessary artificial administrative regulation.

Certainly the administration's proposal is professionally preferable to the various proposals which have been made in the past such as in the so-called Douglas amendment which would seek to forever denominate the services of all hospital-based physicians as hospital services.

In conclusion, I would certainly be remiss if I did not express my personal appreciation and that of the organization which I represent for the personal courtesy and general cooperation which we have received in our personal dealings from Secretary Gardner, Commissioner Ball, Mr. Arthur Hess, and Mr. Melvin Blumenthal, legal counsel for the Social Security Administration. Their dedication is exemplary and in no way have we intended any of our remarks to reflect on their personal integrity and devotion.

The College of American Pathologists is deeply grateful for the opportunity you have afforded us to submit this statement for the record and for the opportunity to make our views personally known to you on these most important proposed legislative changes.

Finally, I might add that I have appended to our statement a one-page summary which documents our feelings concerning the proposed part C.

I wish to thank you, Mr. Chairman, for the opportunity of being here.

(The information referred to follows:)

SUMMARY OF RECOMMENDATIONS OF THE COLLEGE OF AMERICAN PATHOLOGISTS ON
H.R. 5710, 90TH CONGRESS

(1) Present provisions of P.L. 89-97, 89th Congress, as administered under regulations promulgated by HEW are disruptive of existing patterns of hospital-pathologist relationships and deny to the pathologist payment under Part B for a large part of the pathologist's professional practice of Medicine.

(2) Professional reimbursement for pathology (laboratory) services to hospital inpatients should be through the Part B carrier from Part B trust funds with the same \$50.00 deductible and 20% coinsurance applicable to all physicians' services.

(3) The provision of H.R. 5710 which would establish a new Part C, although deficient in a number of aspects and not as professionally satisfactory as (2) above, is substantially preferable to the existing law as interpreted and applied by the administrative regulations.

(4) The provisions of the new Part C relating to outpatient services in hospitals is to be commended as a very practical solution to an extremely confused situation.

Mr. BURKE. Thank you, Dr. Simard.

Are there any questions?

The committee appreciates your appearance and the information you have given us.

Dr. SIMARD. Thank you.

Mr. BYRNES. Mr. Chairman, my attention has been directed to a statement submitted by the College of American Pathologists to the Social Security Administration in regard to the proposed regulations governing hospital-based physicians on July 25, 1966. I believe this statement will be helpful in the consideration of a new section—part C—to the medicare program. I would like to have the statement included in the record at this point.

The CHAIRMAN. Without objection, the statement will appear at this point.

(The statement referred to follows:)

STATEMENT OF THE COLLEGE OF AMERICAN PATHOLOGISTS TO THE SOCIAL SECURITY
ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON REG-
ULATIONS GOVERNING HOSPITAL BASED PHYSICIANS, JULY 25, 1966

JULY 25, 1966.

(Re "Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians," proposed regulations—subpart D, part 405 (regulations 5).

HON. ROBERT M. BALL,

*Commissioner of Social Security, Department of Health, Education and Welfare,
Washington, D.C.*

DEAR MR. COMMISSIONER: We represent the College of American Pathologists and are writing on the College's behalf to comment on the "Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians" which the Department of Health, Education, and Welfare (HEW) proposes as regulations under Title XVIII of the Social Security Act.

In the view of the College, the proposed regulations are contrary to law in a number of material respects and should be rewritten and substantially modified prior to final adoption. Our principal objections are outlined below under appropriate headings:

DISCRIMINATORY TREATMENT OF SPECIALISTS AND HOSPITAL-BASED PHYSICIANS

Perhaps the most basic objection which the College has to the proposed regulations is that they are discriminatory in two respects: they discriminate against

physician specialists by treating them differently than other physicians, and they discriminate against so-called "hospital-based" physicians by treating them differently than non-hospital-based physicians.

These points are easily demonstrated. Instead of treating a pathologist's total medical service as the applicable, "physician's service," for example, the proposed regulations continue the concept first promulgated in HEW's prior Principle Three that the "professional component" of the physician's service which can be reimbursed out of Part B "is only that part of his professional services with respect to which he is personally involved in the provision of services to individual patients" (Section 405.483(b)). The proposed regulations—both in the formal sections and in the illustrations—repeatedly and explicitly devise tests and standards for so-called "hospital-based" physicians which are not made applicable to non-hospital-based physicians but which in fact will result in completely different treatment of charges depending upon where the physician is "based." An example is the charge of the "hospital-based" physician who uses the hospital as his billing agent compared with the charge of the physician who bills from his private office. In fact, all of the devices used in the proposed regulations for segregating "professional components," distinguishing hospital costs from physician's costs, establishing the reasonableness of charges, etc., will in practice be applicable to only a special group. That was not the congressional intent.

In a number of separate reports interpreting the Act, congressional committees made abundantly clear that pathologists' services, without qualification as to their relationship to individual patients, were physicians' services and were to be paid out of Part B funds. In view of the pivotal role played by the House Committee on Ways and Means in the ultimate passage of the Act, its reports are particularly instructive. The Committee stated that payment would not be made under Part A "for the hospital services of physicians" (H.R. Rep. No. 213, 89th Cong., 1st Sess. 5 (1965)), that Part B would cover "Physicians' and surgeons' services" (id. at 7), that there would be no coverage under Part A of "physicians' services" (id. at 22, 26), and that excluded from Part A would be "the in-hospital costs arising from the professional services of * * * pathologists * * * (the costs for such services would be covered under the supplementary health insurance benefits plan)" (id. at 55). And the Committee added significantly:

Payments would not be made under the hospital insurance plan for the services of physicians, except services provided by interns and residents in training under approved teaching programs. Like other physicians' services, the services of radiologists, anesthesiologists, pathologists, and other physicians employed by the hospital or working through the hospital would be paid for under the voluntary supplementary plan; such services would not be covered under the hospital insurance plan. However, the services of the nonphysicians aiding such persons would be covered under the hospital insurance plan. (Id. at 24; emphasis added.)

The same Committee described Part B in a second report as including "physicians and surgeon services (including anesthesiologist, Pathologist, radiologist, and physical medicine in hospital) * * *." (Committee Print, "Actuarial Cost Estimates and Summary of the Old-Age, Survivors, and Disability Insurance System (etc.)," 89th Cong., 1st Sess. 50 (1965).) Again, the same Committee stated in still a third report that Part A payments "will not be made for * * * the hospital services of physicians except services" by interns or residents, and that Part B "covers physicians' services." (Comm. Print, "Summary of Major Provisions of Public Law 89-97," 89th Cong., 1st Sess. 2-3, 5 (1965).)

And finally, the same House Committee on Ways and Means, in still a fourth report which summarized the differences between the House and Senate versions of the bill, stated:

"House excluded M. D. services in the field of pathology, radiology, psychiatry, or anesthesiology from basic hospital insurance benefit (but provided for their payment under supplementary medical insurance program). Senate included these services if billed through a hospital. Conference accepted House version." (Committee Print, "Summary of Major Provisions of H. R. 6675," 89th Cong., 1st Sess. 4-5 (1965); emphasis in original.)

The Conference Report made a similar distinction between the House and Senate versions:

"Amendments Nos. 70 and 141: Under the House bill, section 1861(b) of the new title XVIII excluded from the definition of inpatient hospital services the medical or surgical services of physicians. Except for the services of certain

interns and residents in training, physicians' services would not be covered under part A of title XVIII but would be covered only under Part B. Under section 1832(a) of title XVIII, payment could not be made under Part B to a provider of services (a hospital, extended care facility, or a home health agency) for the services of a physician; the payment would have to be made to the beneficiary or, under certain circumstances, to the physician.

"Senate amendment No. 141 added to section 1861(b) of the new title XVIII a provision under which payment under Part A would be made for the services of physicians in the fields of pathology, radiology, physiatry, and anesthesiology when their services are provided by the hospital or under "arrangements" with the hospital. "Arrangements" would be limited to those under which receipt of payment by the hospital discharged the liability of the beneficiary or any other person to pay for the specialist's services. Amendment No. 70 modified section 1832(a) of the new title XVIII to permit payment to be made under Part B of the new title to a provider of services for physicians' services in the fields of pathology, radiology, physiatry, or anesthesiology where the physician's services were furnished by the physician under arrangements with the provider of services.

"The conference agreement follows the House bill with a technical amendment of Senate amendment No. 70." (H.R. Rep. No. 682, 89th Cong., 1st Sess. 38-39 (1965); emphasis added.)

In the same vein, a Senate document filed after the passage of the Act, stated flatly that payment would not be made under Part A "for the hospital services of physicians" and that:

"Like other physicians' services, the services of radiologists, anesthesiologists, pathologists, and other physicians employed by the hospital or working through the hospital would be paid for under the voluntary supplementary plan; such services would not be covered under the hospital insurance plan. However, the services of the nonphysician technicians aiding such persons would be covered under the hospital insurance plan." (S. Doc. No. 46, 89th Cong., 1st Sess. 2-3 (1965); (emphasis added).)

These same views were expressed by influential Senators on the floor. For example, Senator Douglas said that " * * the services of these specialists will be paid for under the House bill only under the voluntary insurance portion of the bill and only if a specific fee is charged by the doctor involved." Cong. Rec. 6017 (daily rec. Mar. 29, 1965). And Senator Long stated that "As to the coverage of the physician-specialists under the basic program, the House conferees were insistent that physicians services should be placed in the voluntary supplementary program where the private sector will play a greater role as a buffer between the doctor and the Government." Cong. Rec. 17712 (daily rec. July 27, 1965).

Thus, we find totally missing from the detailed congressional report any discussion, or even mention, of a distinction between personal services to the patient and a physician's medical service generally. Nor do we find any attempt to segregate out physician specialists from other physicians. Surely, if Congress had intended to distinguish specialists and other physicians, or between a physician's service directed to an individual patient on the one hand, and a service more generally and impersonally directed on the other, the congressional committees concerned with this bill would have discussed these distinctions somewhere in one of their many reports.

If the nature of the services performed by hospital-based sepecialists had never been called to the attention of Congress, perhaps HEW would have some basis for arguing that the proposed regulations merely fill an unforeseen void. Such, however, is not the case. Congress repeatedly was told that hospital-based pathologists, for example, have virtually no personal contact with individual patients and that it is only the occasional specimen or file that receives their direct, personal attention. This was, in fact, one of the reasons given by HEW for supporting the Senate bills (sometimes almost interchangeably referred to as the Douglas Amendment, No. 156), which were ultimately rejected in favor of the House version. (See, for example, Hearings Before the Senate Committee on Finance, 89th Cong., 1st Sess. pt. 2, at 732 (1965); Hearings Before the Senate Committee on Finance, supra pt. 1, at 447 and pt. 2 at 637-639).

Both the Senate and the House considered at great length the status of medical specialists under this important and highly controversial legislation. They concluded that these physicians were to be treated like all other physicians and that their patients were to be reimbursed only from the optional Plan B funds.

To ward off any possible misconstruction of their intent, each chamber included the explicit admonition in their respective reports that under no circumstances would the charge for physicians' services, as defined in the Act, be reimbursable under Part A. Congress decided that Part A funds simply would not be used to pay for the professional services of physicians.

Congress was also fully informed that traditionally hospitals have billed patients for the professional supervisory service of the pathologist in their laboratory billings. Several witnesses apprised Congress that it was the custom to include on hospital bills a charge in conjunction with pathology procedures attributable to the component value of the physicians' supervisory service.

Dr. Donovan Ward, President of the American Medical Association, told the Congress:

"It is common knowledge in the profession that in most hospitals, the operation of laboratory and X-ray departments results in excessive charges to patients, charges which substantially exceed the actual operational cost. The inclusion of specialists' services as part of the overall charge tends to obscure these 'profits.' * * *." (Hearings Before the Senate Committee on Finance, 89th Cong., 1st Sess., pt. 2, at 612 (1965).)

Similarly, Dr. Victor Buhler, the President of the College of American Pathologists, testified:

"Most pathologists practicing in hospitals have an arrangement with the hospital whereby the hospital keeps a percentage of the total charge for laboratory services to reimburse the hospital for the direct (personnel, equipment, et cetera) and indirect costs involved in the operation of the laboratory. The remainder of the charge, after payment to the hospital of its cost, represents the professional fee of the pathologist. * * *

"The cost to the hospital of the performance of a test, and the cost of the professional service, subtracted from the overall charges to the patient, is income that accrues to the hospital as profit. * * *." (Hearings Before the Senate Committee on Finance, *supra*, pt. 2 at 790, 796.)

Repeatedly, HEW made clear its position—which was the same as that of hospitals profiting from a total billing procedure—that the services of medical specialists should be considered hospital services and reimbursable under Part A. Thus, in his appearance before the Senate to testify on the bill which ultimately became the law, the Secretary implored the Congress to place specialists' services under Part A.

"Mr. Chairman, it would be a mistake, in my opinion, to exclude from coverage under the basic hospital insurance plan, as H.R. 6675 does, the services furnished hospital patients under arrangements with the hospital, by medical specialists in the fields of radiology, anesthesiology, pathology, and physical medicine. These services should be covered under the basic hospital insurance plan subject to the conditions set forth in the Senate-passed bill of last year and in the bill introduced in this Congress by the distinguished senior Senator from New Mexico (18/)."

The Secretary continued:

"Our primary concern is that medical services furnished to hospital patients in these fields be covered under this bill in a way that is in accord with the practices that hospitals and the health professions have developed over the years.

"Thus, we believe that the services in question should be covered as part of the hospital benefit if the specialist-hospital arrangement calls for the bill to be paid through the hospital.

"Conversely, we believe that, where the arrangements are that the specialist is not paid by or through the hospital, reimbursement for the specialist's services should be made under the supplementary plan.

"The specialists in these fields work in hospitals under various kinds of arrangements. Some work as hospital employees and are paid a salary, while others receive agreed upon percentages of the hospital's receipts for the services they furnish. Some of these specialists bill their patients directly.

"The approach we suggest would follow whatever practices now exist or whatever practices may be arranged in the future in this field. On the other hand, the provisions in H.R. 6675, which exclude the hospital-related services of these specialists from coverage under the basic hospital insurance provisions would require substantial changes in the way these services are now paid for." (Hearings Before the Senate Committee on Finance, *supra*, pt. 1, at 98.)

So strong were the Secretary's feelings on this subject that he subsequently offered an amendment making specialists' services reimbursable under Part A rather than under Part B. (Hearings before the Senate Committee on Finance, *supra*, pt. 1, at 113.)

It appears to the College, therefore, that HEW is attempting to carry over into the proposed regulations a number of concepts and assumptions which were specifically considered and rejected by Congress. By failing to treat all physicians alike, by continuing to distinguish between personal and non-personal services, by applying tests to specialists that are not applicable to any other physician, by evolving standards for "hospital-based" physicians which have no relation to those who practice in their own offices—by all of these means and methods, HEW has moved directly contrary to the congressional will.

THE FRACTIONATION OF THE CHARGES FOR PHYSICIANS' SERVICES

The proposed regulations unlawfully break up a physician's service into parts, assigning one part to part A and another to Part B, depending upon the particular arrangement for billing and payment reached by the hospital and the physician.

Thus, Section 405.486 in effect provides that if the billing for physicians' services happens to be by or through the hospital, the cost component of the charge must be reimbursed to the hospital under Part A even if the physician bears some or all of the expense—in other words, even if the hospital in billing the charges is merely acting as an agent for the physician. Conversely, even where the physician bills directly, the cost component of the charge must be reimbursed to the hospital under Part A if the hospital happened to bear some or all of the expense initially, even though such expense is ultimately borne by the physician. Thus, the only time the cost component of a physician's charge is made reimbursable out of Part B funds under these proposed regulations is when the physician bills directly and he initially pays the expense.

There simply is no justification whatever in the Act for this strange treatment of costs. On the contrary, this attempt to pay hospitals for what is properly part of the physician's charge directly conflicts with the law enacted by Congress.

We in no way dispute the propriety of paying a hospital from Part A funds for that part of a physician's time spent in purely educational and administrative duties for the hospital. The proposed regulations go much further, however, and attempt to fractionate what is actually a single charge for a total service. This fractionation is based solely on the type of arrangement which the physician happens to have with the hospital. The proposed regulations thus ignore the fact that a hospital cannot lawfully practice medicine. Only a physician can practice medicine. The medical services rendered by physicians—including the services of physician specialists such as pathologists, anesthesiologists, radiologists, and psychiatrists—can be rendered lawfully only by a physician or under his direction or supervision.

The type of arrangement which a physician might have with a hospital does not alter this basic fact that medical services are rendered by physicians, not hospitals, and as such should clearly be reimbursed from Part B funds.

Thus, when ancillary personnel are performing services incidental to the medical services rendered by the physician, the cost of their assistance becomes merged in the charge for the medical service. The charge for the medical service should not be apportioned between the physician and the ancillary personnel, any more than a practitioner who performs a medical service in his office distinguishes—or is required to distinguish under the Act—between his own personal service and that of his staff operation under his supervision and control. The reasonable charge covers the primary service, including contributing and incidental costs.

We need not belabor the point that Congress did not intend to pay hospitals for physicians' services. Moreover, Section 1832, 1833, 1835, 1842, and 1861(s), although not as artfully drawn as one might wish, make clear that the Part B charge for medical and other health services can include certain costs if sufficiently related to the physician's professional service. HEW in effect recognizes this when it concedes that costs billed by the physician and initially paid by him are properly reimbursable out of Part B funds. Therefore, the area of disagreement between HEW and the College is the wholly unwarranted treatment of the physician's charge as containing elements which, depending on who

bills or who undertakes the expense first, are divisible into Part A and Part B.

Thus, the basic error of the proposed regulations is that they make the initial payment of expenses or the happenstance of billing determinative of whether Part A or Part B funds are to be used, instead of looking at the service to be furnished and the party responsible for rendering the service.

As pointed out above, the real question is not who bills but what is the service and who is the vendor of that service. Nothing in the Act, or in the law generally, supports the concept that a charge truly belongs to the hospital simply because the hospital and the physician have arranged for the hospital to act as the collection agent for the physician. Similarly, it is difficult to comprehend what possible difference it makes who initially bears an expense; the only meaningful question is who in fact is responsible for the service and therefore, ultimately, the expense. If a physician is ultimately responsible for the cost of equipment and nonprofessional personnel, for example, it is irrelevant that the hospital may bill for the cost as his agent or that the hospital may initially pay the cost before collection from him or deducting that cost from what he is otherwise entitled to as his professional compensation.

This use of billing by HEW as a determinative factor in the choice of reimbursement funds is reminiscent of the Senate version of Medicare, which was defeated. It will be recalled that the Senate sought to provide that a service would be a Part A service if it was provided by the hospital (or by others under contract with it), and the billing was done by the hospital. S. 70,141; Committee Print, "Summary of Major Provisions of H.R. 6675, "89th Cong., 1st Sess. 4-5 (1965); H.R. Rep. No. 682, 89th Cong., 1st Sess. 38-39 (1965); Cong. Rec. 6017, 15516, 15522 (daily ed. Mar. 29, July 9, 1965). This concept was rejected by Congress, and it should not be resurrected now in the form of proposed regulations.

The law as enacted deals with a total service, not one divisible into components. It is no answer to rely upon Sections 1832 and 1861(W) as has been suggested by HEW personnel. Since Section 1832(2)(B) specifically excludes "physicians' services," the "arrangements" referred to in that section cannot be an arrangement with a physician. The section applies only to services other than physicians' services.

It appears to the College that the basic error upon which HEW is proceeding in this regard is in assuming that simply because a hospital sends a bill, it in turn is "compensating" a specialist for his services. In most cases (with the single exception of the straight salary situation), the specialist is paying the hospital by one method or another for services which it is rendering to him. He renders the medical service to the patient. The hospital, in turn, may provide him certain facilities and services. His total charge is clearly a Part B charge. It is not in whole or in part a Part A charge any more than it would become one if he used an agency to collect his bills. The proposed regulations in this respect are simply unlawful.

THE ROLE OF THE PART A INTERMEDIARY

As we have pointed out above, once a charge is determined to be for a physician's service, it should not be broken down into components, and the Part B carrier should be solely responsible for deciding any question as to whether the charge is reasonable. The Part A intermediary has no proper role in any such decision.

Nevertheless, regardless of which view HEW takes of the physician's service and regardless of whether or not HEW adopts the interpretation of the Act outlined above, the fact remains that the proposed regulations wrongly place into the hands of parties who are selected and often controlled by hospitals the decision as to what will, and what will not, be deemed a reasonable charge by the physician.

Thus, Section 405.484(a) provides in part that the Secretary will respect an agreement between a hospital and a physician as to that portion of the physician's compensation to be attributed to the care of individual patients (which in turn will form one basis for the reasonable charge under Part B). However, if the hospital and the physician fail to agree, or if their agreement "appears" unreasonable, "it will be the function of the fiscal intermediary handling payments under the hospital insurance program and the carrier handling payments under the supplementary medical insurance program to resolve the issue—by negotiation if possible, otherwise by time studies or other suitable methods. * * *

standards are set forth by which one can tell when an agreement "appears" unreasonable, and there is no amplification of the clear implication that the Part A intermediary will finally resolve, along with the Part B carrier, any dispute over a hospital-physician agreement.

Similarly, Section 405.485(b) states in part that while the present level of compensation for hospital-based physicians is assumed to be reasonable, that assumption "is open to challenge in any given case, and the carriers must deal with such challenges on the basis of prevailing rates of compensation in comparable institutions." Here again, the Part A intermediary presumably not only can challenge the reasonableness of present levels of compensation but can exercise a direct hand, along with the Part B carrier, in resolving the issue. Moreover, the proposed regulation completely fails to set forth who is to finally determine the issue if the Part A intermediary and the Part B carrier cannot agree. HEW officials are frank to admit that they have not provided for such a contingency, and they say that they can only hope it does not arise. Our judgment is that it may well arise, and arise often, if the Part A intermediary can dispute the reasonableness of compensation in the first instance.

Section 405.487(b) begins with the general proposition that a hospital-physician agreement as to that portion of the physician's compensation to be allocated to Part B reimbursement will generally be accepted, assuming an adequate rationale. The section then goes on to provide, however, that "If either the Part A intermediary or Part B carrier believes that the rationale does not justify the allocation, it will notify the other so that coordinated action, if necessary, can be undertaken" (emphasis added). "Coordinated action" is not defined, nor is there any guide as to what will happen if the Part A intermediary and the Part B carrier cannot agree. The section is clear, however, that the Part A intermediary alone can challenge an allocation merely on the basis of a "belief" rather than after a demonstration of unreasonableness.

Illustration (b) (2) provides in part: "The schedule of Part B charges so developed by the hospital and physician is to be submitted by the parties to the Part A intermediary and the Part B carrier" together with certain other specified information, and Illustration (c) provides that "The Part B carrier would approve the schedule of Part B charges if it, with the advice of the Part A intermediary, concurred in the physician's and hospital's determination * * *" (emphasis added). Similarly, Illustration (d) (2), involving the optional method of computation, recites that "The schedule of the customary amounts billed by the hospital for the procedure and the uniform percentage as computed will be submitted by the hospital and the physician to the Part A intermediary and the Part B carrier" together with certain other specified information, and Illustration (e) provides that "The Part B carrier would approve the uniform percentage computed in accordance with subsection (d) if it, with the advice of the Part A intermediary, concurred in the physicians' and hospitals' determinations under subsections (d) (2) (i) and (d) (2) (ii) and provided that the respective amounts so determined are not significantly different" (emphasis added). In these illustrations, the Part B carrier at least is presumably free to ignore the advice of the Part A intermediary, but the fact remains that all information must be furnished to the Part A intermediary, and its advice must be sought and evaluated before a decision as to reasonableness can be reached.

While we have listed above those provisions which specifically spell out a role to be played by the Part A intermediary, it should also be noted that a number of sections in the proposed regulations delineate standards or requirements without specifying who is responsible for reaching a decision in the event of a dispute. Thus, it may well be that, *sub silentio*, the proposed regulations award the Part A intermediary an even more significant role in enforcement than appears from the literal language of the regulations.

In summary, either explicitly or by implication, the Part A intermediary is permitted under these proposed regulations to challenge any or all of the basic considerations that enter into the determination of reasonable charges and to have a hand in resolving such challenges. In some instances, the Part A intermediary may well have either the decisive voice in resolving the challenge or at least the ability to prevent a final resolution of the matter by the Part B carrier.

The plain fact is that in at least three-fifths of the states, the Part A intermediary will be controlled by hospitals. (The trade-mark of Blue Cross, for example, is owned by the American Hospital Association.) In all instances, the hospitals will select the Part A intermediaries. And the hospitals, in turn,

may often have a viewpoint as to costs, charges, billing and reimbursement different from that of physicians. The net effect of the proposed regulations, in our judgment, will be to give the hospitals what amounts to double leverage in dealing with physicians. That is, the hospitals can negotiate their physician agreements with full knowledge of their control over the Part A intermediary, combined with the power of the Part A intermediary to challenge and perhaps even change any or all assumptions underlying the determination of Part B charges. The net effect will be to destroy the physician's ability to negotiate on an equal basis with his hospital; he will be, in all meaningful senses, at the mercy of his hospital, contrary to the intent of Section 1801 of the Act.

The College submits that this power awarded to the Part A intermediary is contrary to law. Section 1816 of the Act, which allows the Secretary to enter into agreements with Part A intermediaries, does not confer upon the intermediary any such power. Section 1842 deals with Part B carriers. It is quite true, of course, that the section refers in part to carriers under Section 1816, but clearly this reference was included because of the few states in which Blue Shield provides both physician and hospital service coverage. In other words, Congress wanted to make certain that the Secretary could enter into a single contract where the carrier provided full coverage. But Congress did not mean to legislate that the Part A intermediary who provides only hospital service coverage can determine the reasonableness of Part B charges. It should be noted in this regard that in determining the amount of benefits, the Secretary is given full power as to the amount of Part A benefits but not as to the amount of Part B benefits. (See Section 1869(a) of the Act.)

In our judgment, the only provision that is both fair and in conformity with the law is that if the hospital and the physician agree as to an allocation of compensation to the care of patients, that agreement stands unless demonstrated to be clearly unreasonable. In that event, it is solely the function of the Part B carrier to determine reasonableness. The same principle would apply to each of the other sections involving criteria and assumptions that determine or underlie Part B charges. The Part A intermediary should have no voice at all in the determination of a Part B charge, and we strongly urge that the proposed regulations be amended to make this proposition abundantly clear.

THE ERRONEOUS RECONSTRUCTION OF COSTS AND CHARGES

Sections 405.483(c)(3) and 405.485(a), and each of the illustrations accompanying the proposed regulations, all suffer from a common failing: They assume that the Part B payment for each individual procedure must be so constructed and devised as to equal in the aggregate a specified sum, namely, that part of the physician's total compensation which has been properly allocated to personal service for patients. To put it another way, the proposed regulations begin with a compensation factor and, by a process of division and/or multiplication, reconstruct what each procedure should be worth. But that is not the method which Congress envisaged. Congress repeatedly emphasized that the cost or charge itself is to be tested against a standard of reasonableness. If the cost or charge is found reasonable under all the circumstances, it must be deemed a proper one, regardless of what all costs and all charges might equal in the aggregate.

For example, Congress declared in Section 1814(b) that "The amount paid to any provider of services with respect to services for which payment may be made under this part (Part A) shall, subject to the provisions of Section 1813, be the reasonable cost of such services * * *," in Section 1833(a)(1) that 80 percent "of the reasonable charges for the services" shall be paid; in Section 1833(a)(2) that 80 percent "of the reasonable cost of the services" shall be paid; in Section 1842(a)(1)(A) and (b)(3)(B)(i) that contracts can "make determinations of the rates and amounts of payments * * * on a reasonable cost or reasonably charge basis" and that a Part B charge "will be reasonable;" in Section 1842(b)(3) that in determining reasonable charges, "customary charges for similar services generally" by the provider and "prevailing charges in the locality" shall be taken into consideration; and in Section 1861(v)(1) that "The reasonable cost of any services shall be determined in accordance with regulations * * *." In each instance, Congress chose not to define reasonableness in terms of an overall impact, a gross amount, or a relationship with compensation. Rather, the language and context of each reference to reasonable costs and

charges make quite clear that it was the individual cost and charge that was to be evaluated and judged. If a charge for a bone marrow test is reasonable, and a charge for a blood test is also reasonable, reimbursement should automatically follow even if when each charge for each service is added together, the total does not precisely equal some prior allocation of compensation.

For this reason, we urge the elimination of each and every provision—and particularly those in the illustrations—which judges reasonableness on any basis other than the reasonableness of the individual cost or procedure under consideration.

THE EMPHASIS ON PAST PRACTICES

The Medicare Act speaks of reasonable charges and reasonable costs in the present tense. The Act says nothing about testing reasonableness on the basis of past practices. The charge or cost to be tested is the present charge or cost—the one in existence at the time the test is made—and the standards to be applied are those then prevailing rather than those that applied at some previous point in time.

The proposed regulations, on the other hand, repeatedly apply past practices and past experience as tests of present reasonableness. HEW personnel have explained this informally by stating that these references to past events are solely for the purpose of reaching underlying assumptions during the first year of Medicare's operation. The proposed regulations, however, are subject to misinterpretation on this point.

Thus, Section 405.485(b) provides that in separating the physician's professional component from the other components of his service, the "present level of compensation" is presumed to be reasonable, and challenges to such an assumption must be dealt with "on the basis of prevailing rates of compensation in comparable institutions." And Section 405.486(b)(3) states that the objective in determining reasonable charges where the physician bills patients directly is the same as that expressed above, "to bring about as little change as possible (in the normal case) in the compensation the physician receives for for his professional services in the hospital."

Similarly, the reasonable charges of a physician who assumes all costs and who bills directly "would be based upon the remuneration he received for his services prior to the leasing arrangement plus his reasonable costs of operation as reflected by the hospital's cost experience in providing such services" (Section 405.486(b)(4)). In other words, the reasonableness of the physician's costs as well as his fee would be based on costs and remuneration from prior years. Section 405.488(b) adds that the total costs of services to patients "should not be increased solely by reason of" the division of payments under Part A and Part B, and Illustrations (b)(2)(ii) and (d)(2) require the submission of data showing, under both the item-by-item approach and the optional approach, the "customary amount(s) billed by the hospital for the procedure." In addition, under the item-by-item approach, an estimate of the number of times the procedure will be performed in the next year must be accompanied by "Comparable data for a representative past period—e.g., a year—" and an explanation of "any significant deviations" between the two (Illustration (b)(2)(i)).

It is quite true that Sections 405.485(b) and 405.486(b)(4) and Illustration (a)(1) seem to recognize that revisions, adjustments and changes in past practices will be recognized in some cases and under certain conditions. These provisions, however, are not sufficiently clear and are too restrictive. If HEW really intends, as its officials have informally assured the College they do intend, that past practices are to be used as a guide solely for judging the reasonableness of charges and costs during the first year of Medicare's operation, when the shifts from the old system to the new will take place, then that proposition should be clearly spelled out in the regulations. After the first year of operation, costs and charges should be allowed to ebb and flow with the demands of the profession subject only to the requirement of reasonableness, and reasonableness must be judged on the basis of all relevant facts then in existence and not on the basis of what may have prevailed in the past.

In this regard, it should be noted that Congress was careful to provide at the very outset of the Act that Federal officials shall not supervise or control the practice of medicine, the manner in which medical services are provided, the compensation of persons providing health services, etc. (Section 1801). As pointed out above, the Act does not speak in terms of past practices. It does not

attempt to inhibit change. It does not require any explanation of deviations from one year to the next. On the contrary, when the Act sets forth standards of reasonableness, it refers to other conditions then prevailing. For example, in referring to reasonable charges under Section 1842(b)(3)(i), the Act sets out that the charge shall not be higher "than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier * * *." Similarly, Section 1842(b)(3) reads in part: "In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services." These sections do not relate back to customary and prevailing charges or comparable service and circumstances of other years. Instead, they pinpoint the present as the relevant period for comparison. The proposed regulations should do the same.

WHETHER THE "ILLUSTRATIONS" ARE EXAMPLES ONLY

The "Illustrations" published with the proposed regulations are described in the covering notice as "illustrative methods for applying the principles described in Sections 405.480 through 405.888 * * *." The text of the illustrations themselves, however, will almost certainly lead those concerned with enforcement to believe that these are not merely illustrations or examples, but rather binding delineations of how to separate physician payments into Part A and Part B components and of how to determine the Part B charge for individual procedures.

We have pointed out above that the illustrations proceed on the wrong basis and are illegal, but the point we make here is that even assuming the illustrations to be permissible, they certainly cannot be made the only basis for separating payments and determining charges. Congress carefully provided that the sole test is reasonableness. Any separation of Part A and Part B payments and any establishment of Part B charges that result in reasonable determinations must be deemed acceptable under the Act no matter how evolved. Reasonableness is to be tested by the result and not by the method used to reach it.

The Use of the Optional Method

Illustration (d)(1) provides in part that "Where, because of the high volume of low-cost procedures or the lack of necessary statistical data, it would not be feasible for the physician and hospital to comply with the requirements of the item-by-item method, the optional method described in Section 405.483(c) would be applicable" (emphasis added). HEW officials have stated that they do not intend for the optional method to be used only when it can be demonstrated that use of the item-by-item method is not feasible. On the contrary, these officials have stated that the optional method can be used whenever the physician chooses to use it. However, the fact remains that the illustration reads otherwise, and those whose duty it is to interpret and apply the regulations may well feel themselves bound by the literal language of this illustration to disallow the optional method whenever the item-by-item method appears feasible or whenever the parties have failed to demonstrate that the item method is not feasible. The illustration should be changed by eliminating entirely the sentence from the illustration quoted above.

This point is particularly important in view of our position, previously submitted in detail to HEW and discussed briefly again above, that the requirement of personal attention to an individual patient by the physician—a requirement which forms the basis of the item-by-item approach—is contrary to law.

In the light of the above comments, we respectfully request and urge the Department to rewrite and substantially modify its proposed regulations.

Sincerely yours,

E. BARRETT PRETTYMAN, JR.

Mr. BURKE. Our next witness is Dr. Milton Terris. Will you identify yourself for the record, Doctor?

**STATEMENT OF DR. MILTON TERRIS, PRESIDENT, AMERICAN
PUBLIC HEALTH ASSOCIATION**

Dr. TERRIS. Mr. Chairman and members of the committee, I am Dr. Milton Terris, president of the American Public Health Association. I am also professor of preventive medicine at the New York Medical College in New York City.

Despite the brevity of experience with Public Law 89-97, I believe we can make the judgment that the benefits of the medicare program in meeting the health needs of persons age 65 and over is abundantly evident.

It is also evident that the program is imperfect, that it needs to be improved, it needs to be continued, and that it needs to be broadened.

In our approach to viewing Public Law 89-97 and title XVIII we work from the standpoint of two principles: One, that fiscal integrity must be preserved, and two, that effective health care appropriate to need must be provided. It is our opinion that these objectives are not mutually exclusive, that they can and should be made compatible.

We believe that the goal of both Federal and State programs should be achievement of a single uniformly high standard of medical care, not a system which permits a high level of care for certain sections of the population and an inferior level of care for other sections of the population. It is our belief that other considerations must be secondary to this point of view.

Our first recommendation is that title XVIII be amended in order that all existing arrangements for providing physicians' services, including salaried physicians and group health plans, be eligible for reimbursement.

Despite the statement in the original act that the intent of the bill was in no way to interfere with the practice of medicine or with the manner in which medical services are provided, the law has done just that. The rigidity of the required fee-for-service payment system has made necessary an artificial accounting for services rendered under other systems of reimbursement. It has been a direct interference with the best in medical practice. It has made necessary a complicated system of medical cost accounting maintained at an unnecessary expense.

In the United States at the present time there is an increasing tendency toward the development of prepaid group practice and toward the use of salaried physicians in hospitals. These tendencies are very important from two points of view. They are highly significant in improving the quality of services available to people. They are also very important because studies have shown that under these relationships the costs of effective care are considerably lower than under the fee-for-service system.

We would submit that it is extremely important that we do not turn the clock back with regard to these newer developments which are occurring in medical practice, that no legislation should interfere with the possibility of progress in these areas.

Now, although section 130 of H.R. 5710 makes a beginning effort to better the present situation by covering hospital inpatient X-ray and laboratory services, we believe that a far greater improvement

would result if all salaried hospital-based specialist services were covered under part A.

A second recommendation is that title XVIII be amended to eliminate the required 3-day hospital stay prior to admission to an extended care or nursing home facility. We recognize the reason for this provision, but we suggest that the presently required 3-day hospital stay does not necessarily accomplish the objective of making certain that the patient has a real medical evaluation before he enters the extended care or nursing home facility.

We suggest instead that there be required a medical evaluation with prescribed criteria, including a determination of rehabilitation potential, before admission to an extended care facility, a nursing home, or release to a home health agency.

We believe the present provision may require unnecessary expensive hospital stays without realizing the objective of that provision.

We recommend an amendment to title XVIII to eliminate all deductibles. We know of no proof that deductibles furnish any real deterrent to the seeking of unnecessary care by individuals and there is considerable indication that the deductibles may discourage patients from seeking care early in an episode of illness. The administrative nightmare which has resulted from the deductibles has already been covered in other testimony before this committee. I will not repeat this.

The American Public Health Association recommends that title XVIII be amended so that depreciation allowances to institutions, whether under voluntary or proprietary auspices, are predicated on funding such allowances, and we agree with the provisions of H.R. 5710 except that we would add two things.

First, we think it would be simpler to retain the depreciation allowance in the medicare fund with arrangements whereby an institution would have a charge against said allowance when capital expenditures are to be made, and this would eliminate the need for expensive and cumbersome recapture provisions.

Secondly, we believe the depreciation allowance should be made only when it is consistent with the State plan. However, we consider that the State agency from whom approval is required should be the State agency which has the responsibility for total health facility planning and not necessarily the agency designated pursuant to section 1864(c).

Our next recommendation is that title XVIII be amended to include as a reimbursable charge the cost of prescription drugs for out-of-institutional care where medically indicated. Making drugs available to patients whose medical condition has been stabilized is sound preventive medicine which in many cases will obviate the need for more costly rehospitalization. Most beneficiaries would prefer to remain in their homes and if their health can be protected in this environment it is preferential to do so from both the viewpoint of choice by the patient and from the viewpoint of cost. We have long supported the position that public expenditures for prescription drugs should be made on the basis of generic name. This stand is based upon a belief that effective drugs should be provided at the lowest possible cost.

It appears to us, and we hope the committee will be equally convinced, that in the interest of guarding the financial integrity of the program it should be required that drugs be prescribed generically whenever possible from a formulary in which only the products of approved manufacturers would be listed.

Our final recommendation on title XVIII is that there be an amendment whereby home health services would be expanded so as to provide comprehensive health care. At the present time the services of such specialists as nutritionists and dietitians are not available under title XVIII.

With respect to title XIX, it is the opinion of the American Public Health Association that title XIX is not now meeting the demonstrated health needs of those for whom it is intended, and there is grave doubt in our view as to whether or not it can meet those needs.

Certainly the less fortunate States economically have not and probably will not be able to finance their share of this program, and we believe the Congress must sooner or later consider adopting one of two alternatives.

The first is Federal support of the title XIX program up to and including 100 percent. We would prefer the second alternative, which is the broadening of the Federal health insurance program, title XVIII, to include title XIX beneficiaries.

The American Public Health Association has for a number of years been persuaded that the paid up insurance method is preferred, and we believe that the provision of health care to individuals who have prepaid for the services received means that they receive services as a right rather than a privilege. Further, this means a great deal in terms of the kind of care they get.

We would like to point out to the committee that the proposal in H.R. 5710 which essentially defines medical indigency runs into some difficulty. In our studies of these questions we have found it extremely difficult to define medical indigency. While it is possible to anticipate with a reasonable degree of accuracy costs for food, clothing, and shelter, medical problems and their attendant costs are completely unpredictable. A family of modestly comfortable means can in the face of a health catastrophe be thrown into a tragic indebtedness.

It is because of just such instances that the APHA favors prepaid health insurance protection and we urge serious committee consideration of this approach.

With regard to title XIX, we should like to recommend more attention be paid to the question of quality and the question of standards. We recommend that XIX be amended to vest in State health departments authority to certify providers of service from practitioner through facility financed under this title.

With respect to the maternal and child health programs we support the proposals in H.R. 5710 with enthusiasm. We believe, however, that these programs should be coordinated with the programs developed by the State health planning agencies. We support the new requirements that a certain small proportion of the funds for this activity be set aside for a program of evaluation.

This is in our opinion a long overdue step. We should like to see it made a part of all Federal granting programs in the health field.

We support the proposals in H.R. 5710 for programs of dental health of children and we believe further that this program should be administered by the agency within the department which is most experienced and qualified to do so, the dental health program of the Public Health Service.

Finally, we should like to bring to the attention of the committee the need for a new federally supported program to aid in the financing of care in nonmedical homes, residences, or institutions for the aged who do not need constant medical or nursing care. These facilities would, for example, provide a home for the ambulatory patient who needs only occasional medical attention. Such a program would help prevent overutilization of hospital and nursing home facilities while providing a site for needed care at less cost than if the patient were institutionalized.

We believe this kind of program is necessary if we are to prevent the misuse of costly health facilities and safeguard the financial integrity of the program.

Thank you very much.

(The statement referred to follows:)

STATEMENT OF MILTON TERRIS, M.D., PRESIDENT, AMERICAN PUBLIC HEALTH ASSOCIATION, ON PUBLIC LAW 89-97 AND H.R. 5710

Less than one year has elapsed since July 1, 1966, when the first of a series of provisions under Title 18 of P.L. 89-97 went into effect. The effective date for other provisions is even more recent, and some are still to become operative. Despite this brevity of experience, we believe that some judgments can be made, that certain problems have become apparent, and that certain specific changes are indicated. The benefits of the Medicare program in meeting the health needs of persons age 65 and over are evident. That it is imperfect is equally evident. That the program should be improved, continued and broadened is, to the APHA, indisputable.

In considering amendments to P.L. 89-97, it is incumbent upon the Congress, and especially this Committee, to weigh carefully both the experiences of the past and the prospects for the future while keeping in mind two especially pertinent factors. First, fiscal integrity must be preserved. Second, effective health care appropriate to need must be provided. These objectives are not mutually exclusive—they can and should be made compatible.

It is the view of the APHA that the justification for enactment of Titles 18 and 19 was the provision of quality health services to beneficiaries in need of them. The goal of both Federal and State programs should be achievement of one uniformly high standard of medical care, not a system which will permit a high level for some and a second inferior grade of medical care for certain population groups. Other considerations must be secondary.

This ambitious new health legislation was not born from a need related to financial profit. Nor should its goal be merely to arrange financial details, spend allotments, and reimburse vendors. There must be continuous attention to how the money is used, and with what effects. Every effort should be made to obtain as much effective health care as possible from the resources available.

The observations and recommendations of the APHA will be related to our sphere of competence—health—and they will be applicable to the two most basic factors—financing and effectiveness of care. This statement will not cover all of the points raised by H.R. 5710, but it will deal with those which, in our view, are most critical in developing the best program possible.

To this end:

The APHA recommends:

Amendment of Title 18, P.L. 89-97, in order that all existing arrangements for providing physicians' services, including salaried physicians and group health plans, will be eligible for reimbursement.

Despite the intent of this Committee and of the Congress to in no way interfere either with the practice of medicine or with the manner in which medical

services are provided, P.L. 89-97 has done just that. The rigidity of the required fee-for-service payment system has made necessary an artificial accounting for services rendered under other systems of reimbursement. It has been a direct interference with the best in medical practice. It has made necessary a complicated system of medical cost accounting maintained at an unnecessary expense. The results are frequently confusing, even ludicrous—patients receiving a physician's bill for a few cents. This cumbersome and costly requirement should be eliminated.

Although Section 130 of H.R. 5710 makes a beginning effort to better this situation by covering diagnostic X-ray and laboratory services, a far greater improvement would result if all salaried hospital based specialist services were covered under Part A.

The APHA recommends:

Amendment of Title 18 to eliminate the required three-day hospital stay prior to admission to an extended care or nursing home facility.

The logic behind this requirement was to assure medical evaluation before placement, but the presently required three-day hospital stay does not necessarily accomplish this objective. We suggest, in its stead, a prerequisite medical evaluation, with prescribed criteria, including a determination of rehabilitation potential, before admission to an extended care facility, a nursing home or release to a home health agency. In many instances, an unnecessary, expensive hospital stay would be eliminated and, in every instance, a plan for a continued regimen of needed service would result. Physicians' services, now possible under Part B, makes possible an out-of-hospital evaluation which was non-reimbursable when this legislation was first conceived as dealing with institutional benefits only. The value of continuity of care, recognized by the requirement for a physician plan, should be constantly emphasized.

The APHA recommends:

Amendment of Title 18 to eliminate all deductibles.

The rationale for deductibles is essentially twofold. First, that they deter the hypochondriac or the merely lonely from seeking unnecessary care, thus preventing unnecessary overcrowding of facilities and overburdening physicians; and second, some financial support of the program is realized. There is no proof that deductibles furnish any such deterrent. And there is indication that they may discourage patients from seeking care early in an episode of illness.

Disregarding completely the value of an early visit in an episode of illness, deductibles contribute to an administrative nightmare. And the labor and concomitant costs involved in record keeping and in the incessant checking and rechecking on deductibles is tremendous. We are advised that overhead costs to intermediaries, a sizeable portion of which is attributable to bookkeeping required to keep track of deductibles, is running between 10 and 18 percent. This, in our view, is inordinately excessive and further, is an unnecessary and unproductive charge against the program. Furthermore, it is an added complexity for the beneficiary himself.

Although the new Part C proposal simplifies some of the confusion which exists currently, and although the uniting of diagnostic and therapeutic outpatient services is most desirable, restricting eligibility for hospital outpatient care to those enrolled under Part B seems to us a deletion of hospital outpatient diagnostic benefits now available under Part A.

The APHA recommends:

Amendment of Title 18 so that depreciation allowances to institutions, whether under voluntary or proprietary auspices, are predicated on funding such allowances.

It is important to keep in mind that this provision of the law is intended specifically for renewing or rebuilding—a depreciation allowance on capital expenditure—and that this return is in addition to (a) a 2 percent unidentifiable cost factor and (b) a return on investment which, based upon the formula incorporated in the law, is presently running about 7.5 percent. The intent of Section 129 in H.R. 5710 appears consistent with our recommendation, but we urge the Committee to consider two modifications.

First, we believe it would be much simpler to retain the depreciation allowance in the Medicare fund with arrangements whereby an institution would have a charge against said allowance when, in accordance with the State health facility planning authority, capital expenditures are to be made. This would eliminate the need for cumbersome recapture provisions.

Second, any capital expenditure by a provider of service should be required to be in conformity with the State plan for facility development. Without such approval, a depreciation allowance should not be made. And, the State agency of whom approval is required should be the State agency which has responsibility for total health facility planning and not necessarily the agency designated pursuant to Section 1864(c), P.L. 89-97.

The APHA recommends:

Amendment of Title 18 to include as a reimbursible charge the cost of prescription drugs for out-of-institutional care where medically indicated.

Making drugs available to patients whose medical condition has been stabilized is sound preventive medicine which, in many cases, will obviate the need for more costly re-hospitalization. Most beneficiaries would prefer to remain in their homes and if their health can be protected in this environment it is preferential to do so from both the choice and cost vantage points. The APHA has long supported the position that public expenditures for prescription drugs should be made on the basis of generic name wherever possible. This stand is based upon a belief that effective drugs should be provided at the lowest possible cost. Examples of price discrepancies between trade and generic name prescribing can be illustrated by three examples of wholesale prices selected at random.

Trade name	Cost per 100	Generic name	Cost per 100
Meticorten (5 milligrams).....	\$17. 90	Prednisone (5 milligrams).....	\$1. 00
Peritrate (10 milligrams).....	2. 50	Pentaerythritol tetranitrate (10 milligrams).....	. 50
Equanil.....	6. 50	Meprobamate.....	3. 00

It appears to us, and we hope this Committee will be equally convinced, that in the interest of guarding the financial integrity of this program it should be required that drugs be prescribed generically whenever possible from a formulary in which only the products of approved manufacturers would be listed.

The APHA recommends:

Amendment of Title 18 whereby home health services would be expanded so as to provide comprehensive health care.

Section 127 of H.R. 5710 would add the services of podiatrists to those of the health disciplines presently included. This action is merited, but additional services should be included. The home is the locale of preference if appropriate health care can be provided there. But whatever the needed specialty may be, it should be available. Section 1861 should be amended in order that the services of indicated specialists (e.g. nutritionists and dieticians) can be reimbursed, hence made readily available.

TITLE XIX

It is the opinion of the APHA that Title 19 is not now meeting the demonstrated health needs of those for whom it is intended. There is, in our view, grave doubt as to whether or not it can. Certainly the less economically fortunate States have not, and probably will not, be able to finance their share of this program. We believe that the Congress must one day consider adopting one of two alternatives. The first is Federal support of the Title 19 program up to and including 100 percent. If we understand the language of H.R. 5710 there seems to be a step in this direction contained in Section 206 of that proposal. A second alternative would be the broadening of the Federal health insurance program to include Title 19 beneficiaries. The APHA has for a number of years been persuaded that the paid up insurance method is preferred.

We believe it incumbent upon us to point out to the Committee our doubts as to the wisdom of the proposal in H.R. 5710, Section 220, whereby Federal participation in Title 10 would be limited to those persons and families whose incomes do not exceed by 50 percent the highest income standards for eligibility under the cash assistance program. While it is possible to anticipate, with a reasonable degree of accuracy costs for food, clothing and shelter, medical problems and their attendant costs are completely unpredictable. A family of modestly comfortable means can, in the face of a health catastrophe, be thrown into a tragic indebtedness. It is because of just such instances that the APHA favors prepaid health insurance protection.

Unless and until public assistance recipients and the medically indigent are covered by the Federal health insurance program, Title 19 should be improved.

To this end:

The APHA recommends:

Amendment of Title 19 to provide 75 percent Federal reimbursement for the compensation and training of professional medical personnel and supporting staff engaged in the administration of this program irrespective of the State agency so administering.

The present arrangement is, in our view, not consistent with the intent of the Congress nor of this Committee when P.L. 89-97 was enacted. We subscribe to and support fully the amendment proposed in Section 224, H.R. 5710, and urge its approval.

The APHA recommends:

Amendment of Title 19 to vest in State Health Departments authority to certify providers of service financed under this Title.

In order to ensure that a uniformly high level of medical care is provided, the qualifications and competence of providers must be certified all along the line—from practitioner through facility. Just as certification of beneficiaries' eligibility is mandated to the unit with the expertise, the State welfare authority, certifying providers should be mandated to the unit with that expertise, the State health authority.

In the interest of curtailing unnecessary administrative work and confusion, we believe it would be helpful if the Department of Health, Education, and Welfare adopted a policy whereby proof of Civil Rights compliance furnished, as required, under Title 18 would be considered valid for Title 19. Neither certifying State agencies nor institutions should be required by a second Federal agency to furnish proof of compliance already submitted to another agency of the same Department.

MATERNAL AND CHILD HEALTH PROGRAMS

Several amendments are proposed in H.R. 5710 (Sections 301, 303, 305 and 306) to accelerate our total effort to improve the health status of our nation's youth. In our view, there are few if any ventures of comparable worth. These programs, the early case-finding and treatment of handicapping conditions of children, the special grants for maternity and infant care, and the training of competent personnel all merit increased support. In the face of ample proof that we can do better, we must. The APHA strongly supports the proposed increases in the authorizations for these programs.

In the interest of maximum accomplishment from programs within States and communities, we urge a requirement in the provisions of Sections 301, 303 and especially 306 of H.R. 5710 that these grant programs be coordinated with the State planning agency required by P.L. 89-749 enacted in October 1966. These vital programs should be made an integral part of the total Federal-State-local health effort.

We support too the innovative and long overdue authority called for in Section 307, H.R. 5710. It is long past the time for a careful evaluation of the results of Federal support and direction of operating health programs. The APHA is persuaded that this should be a part of every Federal grant program and heartily endorses inclusion of this provision. We must state that such evaluation will, in our view, be more objective if made by other than the program administrators. Hence, we hope that the Secretary of HEW will, in every instance possible, seek accomplishment through a grant or contract arrangement with organizations outside the Federal Government.

DENTAL HEALTH OF CHILDREN

Dental diseases and their complications number more victims, adults and children alike, than any other chronic condition. Disease attack is particularly vicious in childhood. It begins almost at birth—usually no later than the second year—destroying first the primary or baby teeth and then, as soon as they erupt, the secondary or permanent teeth and continuing into adulthood for as long as there are teeth left to be attacked. Dental disease can be prevented, but once it is present in the mouth of a child, it can be controlled only through continuous professional care.

The proposed national dental health program for children offers our first real opportunity to break this seemingly endless cycle of disease, neglect, and destruc-

tion. It offers a progressive program of comprehensive dental care to children across the country who would not otherwise receive such care. It is a program which, if extended to all the nation's children, could within a generation virtually eliminate decay as a major cause of tooth loss and bring the other major destructive dental diseases under effective control. We consider this proposal of utmost importance to the health protection of our children, and we urge favorable action by this Committee. We further believe that this program should be administered by the agency within the Department most experienced and qualified to do so, the Dental Health Program of the Public Health Service.

NEW PROGRAM

Finally, the APHA recommends serious consideration by this Committee and the Congress of the need for a new federally supported program to aid in the financing of non-medical homes, residences or institutions for beneficiaries of programs for the aged who do not need constant medical or nursing care. These facilities would, for example, provide a home for the ambulatory patient who needs only occasional medical attention. Such a program would help prevent over-utilization of hospital and nursing home facilities while providing a site for needed care at less cost than if the patient were institutionalized.

Your favorable consideration of these several suggestions will, we believe, do much to improve these valuable health programs.

SUMMARY OF RECOMMENDATIONS OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

APHA recommends specific amendments so as to (a) increase effective health care for beneficiaries while (b) protecting the fiscal integrity of funds for the program by:

UNDER TITLE 18

(1) Making eligible for reimbursement all existing arrangements of providing physicians services, including salaried physicians and group health plans.

(2) Requiring a medical evaluation with prescribed criteria, prior to admission to extended care facility, nursing home, or home health services—delete the three day hospital stay requirement.

(3) Eliminating all deductibles.

(4) Requiring depreciation allowance funding whether institution is under voluntary or proprietary auspices with use of allowance predicated on conformance with state plans.

(5) Reimbursing cost of prescription drugs for out-of-institution care where medically indicated.

(6) Reimbursing for cost of (in addition to podiatrists, Section 127, H.R. 5710) services of necessary personnel, including nutritionists and dieticians, in home health agency programs.

UNDER TITLE 19

(1) Allowing 75 per cent Federal reimbursement for compensation and training of professional medical staff administering state programs, irrespective of public agency so administering.

(2) Vesting in State Health Departments authority to certify providers of health services under this Title.

Federal support of health services to mothers and children should be increased. APHA recommends:

(1) Additional funds for early case finding and treatment of handicapping conditions of children, for special maternity and infant care projects, for maternal and child health services, for personnel training and for research.

(2) Approval of the dental-health-for-children program.

(3) Requirement that each of these grant programs be coordinated with the State Health planning agency (P.L. 89-749).

APHA recommends a new Federal program to help finance non-medical homes, residences or institutions for the aged who do not require constant medical or nursing care.

Mr. BURKE. Thank you very much, Dr. Terris. Are there any questions?

Thank you again, Doctor.

Dr. TERRIS. Thank you.

(The following letter was received by the committee:)

THE AMERICAN PUBLIC HEALTH ASSOCIATION, INC.,
New York, N.Y., April 5, 1967.

HON. WILBUR MILLS,
Chairman, House Committee on Ways and Means, Longworth Office Building,
Washington, D.C.

DEAR MR. CHAIRMAN: I wish to submit to you and for the record of the hearings that you are currently conducting on amendments to the Social Security Act an addendum to the statement which I presented to your Committee on March 13, 1967. I would appreciate it if this letter could be made a part of the statement of the American Public Health Association and the expression of our views relative to needed changes in the Social Security Act.

The Administration has proposed in the bill H.R. 5710 (which you have introduced at their request) to eliminate the comparability standards between the various elements of Title 19 program as contained in Section 1902(a)(10). This feature of Public Law 89-97 as it now stands assures that there will be comparability in the amount, duration, and scope for all beneficiaries of medical assistance under Titles 1, 4, 10, 14, and 16 as well as beneficiaries receiving medical assistance who are in the medically needy group but not receiving cash assistance. This provision means that, if and when state agencies buy into the Part B feature of the Title 18 program, there is assurance that persons under Title 19 will receive the same comprehensive medical services with the same standards of care that are provided under Title 18. The American Public Health Association is convinced of the need for one high standard of effective health care and the proposal of the Administration to eliminate this feature of the present law which guarantees comparability of services would be an invitation to establish a second grade system of welfare medicine. To this the APHA is unalterably opposed. The Administration proposal is a step backward. It would establish a separate and unequal system of care with higher standards for persons over 65 years of age and a lower standard for children and their caretakers, for the disabled and the blind. There is no question that the children of this nation are among the neediest groups in the country and they should not have less, but in fact should have more in the way of high quality, effective health care.

We wish, therefore, to protest the concept which has been introduced by the Administration and we strongly urge you and your Committee to reject the proposal of the Administration contained in Section 223 of H.R. 5710.

Sincerely yours,

MILTON TERRIS, M.D., *President*.

Mr. BURKE. We will now hear from Dr. Mowbray and Dr. Barron.

**STATEMENT OF DR. DOUGLAS T. MOWBRAY, PRESIDENT, AND DR.
EDWIN N. BARRON, RETIRING PRESIDENT, AMERICAN PODI-
ATRY ASSOCIATION**

Dr. MOWBRAY. Mr. Chairman and members of the committee, I am Douglas T. Mowbray, president of the American Podiatry Association and a doctor of podiatry in private practice in Waterloo, Iowa.

Accompanying me is Edwin N. Barron, retiring president of the association and also a doctor of podiatry in private practice in Little Rock, Ark.

The American Podiatry Association is a voluntary, nonprofit organization established in 1912 and composed of 52 component societies—one in each State, the District of Columbia, Puerto Rico, and a society for podiatrists in Federal service.

The American Podiatry Association supports the recommendation of President Johnson to include podiatrists' services in the medicare program. The President first identified this need in July 1965, when he signed the bill and state that:

* * * the benefits under the law are as varied and broad as modern medicine itself * * * and if it has a few defects—such as the method of payment of certain specialists, or the exclusion of podiatrists—these, I am confident, can be quickly remedied * * *

In his message to the 90th Congress on aid to the aged, he observed that—

* * * Certain types of podiatry services are important to the health of the elderly. Yet, these services are excluded under present law * * *

Our statement addresses itself to section 127 of H.R. 5710 which proposes to add these services to the program.

Mr. Chairman, during the 89th Congress your committee carefully considered this matter and in Report No. 2300 approved H.R. 13455 as amended. This bill, introduced by Congressman George M. Rhodes, would have amended the definition of the term "physician" in title XVIII of the Social Security Act to include a doctor of podiatry and cover the services of such doctors under the medicare program.

H.R. 13455 would have also excluded routine foot care as a benefit, whether provided by a podiatrist or medical doctor. This exclusion was also recommended by President Johnson in his recent message.

Our study of your committee's report approved last session clearly indicates, Mr. Chairman, that it was planned to add podiatrists' services to the program in the same manner as other health service disciplines.

The report recognized this in stating that the bill would, in effect, provide that doctors of podiatry be treated under the law in the same manner as medical doctors. The report also recommended that podiatrists' services be excluded from coverage under the hospital insurance program, part A, and covered under the supplementary medical insurance program, part B. This concept is consistent with private health insurance plans.

In other words, your committee recommended that subscribers to the supplementary medical insurance program could select a podiatrist to provide services covered by the plan.

Prior to the enactment of Public Law 89-97, subscribers to private health insurance contracts, including those for persons over 65, could select a podiatrist to perform a covered medical or surgical service on the foot. Public Law 89-97 created an inequity for the insured by not including the services of podiatrists. Your committee's recommendations for amendments to the Medicare Act would correct this inequity.

In sharp contrast, section 127 of H.R. 5710 does not provide a clear understanding of the manner in which podiatrists would participate in the program. These amendments do not appear to fulfill the intent of your committee's report, Report No. 2300, and could cause many administrative problems.

These amendments also raise the question as to whether or not subscribers would have to obtain certification, that the services of podia-

trists were medically required, from such persons as are designated as a "physician" under the provisions of the act.

Similarly, the present proposal implies that podiatrists would not be able to independently order supplies and services required as part of their treatment. These concepts are not consistent with any private health insurance plan and could result in additional costs. The proposal now before your committee, Mr. Chairman, also is not in keeping with the health insurance plans for Federal employees which include the podiatrist in the definition of "physician."

A podiatrist, by legislative enactment in all jurisdictions, is licensed to examine, diagnose, and treat the foot medically and surgically. He, therefore, has been accorded the legal right to the exercise of independent professional judgment. There is a serious question as to whether the provisions of section 127 of H.R. 5710 embody this concept.

SUMMARY

There are only four classes of doctors licensed to treat by medical and surgical means—the medical doctor, osteopath, dentist, and podiatrist. The definition of "physician" in Public Law 89-97 includes all of these except the podiatrist. We respectfully urge that consideration be given to amending this definition to include the podiatrist.

This action would be in compliance with the present law which guarantees a free choice of health services by the patients and prohibits Federal interference. This action would also be consistent with other health insurance plans and would provide for the participation of podiatrists in the medicare program in keeping with the recommendations made by your committee.

In conclusion, Mr. Chairman, I would like to stress several points which are of concern to this committee.

First, including podiatrists' services would help relieve the health manpower shortage. Second, this would also provide for a free choice of services by patients.

Finally, there would be no added costs to the program by including podiatrists' services. This view was expressed by the Health Insurance Association of America in its statement to this committee on March 10.

Section 127 would include nonroutine foot treatment, whether provided by a physician (as at present) or by a qualified podiatrist. Such treatment by podiatrists would justifiably be limited to services of a type covered if performed by a physician. The cost of such an extension of the program should not require an increase in the SMI premium. We would not oppose this extension.

Mr. Chairman, we appreciate the opportunity of presenting this statement on H.R. 5710 and will be pleased to answer any questions you or the members of the committee may have.

(The report referred to follows:)

[H. Rept. 2300, 89th Cong., 2d sess.]

PAYMENT FOR PODIATRISTS' SERVICES UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

The Committee on Ways and Means, to whom was referred the bill (H.R. 13455) to amend title XVIII of the Social Security Act to provide payment for podiatrists' services under the program of supplementary medical insurance

benefits for the aged, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert the following:

"That (a) section 1861(r) of the Social Security Act is amended by inserting before the period at the end thereof the following: ", or (3) a doctor of podiatry or surgical chiropody, but (unless clause (1) of this subsection also applies to him) only with respect to functions which he is legally authorized to perform as such by the State in which he performs them".

"(b) Section 1862(a) of such Act is amended—

"(1) by striking out 'or' at the end of paragraph (11) ;

"(2) by striking out the period at the end of paragraph (12) and inserting in lieu thereof ' ; or ' ; and

"(3) by adding after paragraph (12) the following new paragraph :

"(13) where such expenses are for routine foot care, including the removal of corns or calluses and the trimming of nails."

"SEC. 2. The amendments made by the first section of this Act shall apply with respect to services furnished after December 31, 1966."

Your committee's bill would amend the definition of the term "physician" in title XVIII of the Social Security Act to include a doctor of podiatry or surgical chiropody and thereby cover the services of such doctors under the medicare program. Doctors of podiatry or surgical chiropody are respected members of the health service team, and often perform their services in cooperation with medical doctors. Your committee's bill would, in effect, provide that doctors of podiatry and surgical chiropody be treated under the law in the same manner as medical doctors. Thus their services would be excluded from coverage under the hospital insurance program (part A) and covered under the supplementary medical insurance program (part B).

In line with the exclusion under present law of such services as routine physical checkups, most dental services, eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, examinations for hearing aids, immunizations, etc., your committee's bill would exclude routine foot care such as treatment of corns or calluses and the trimming of nails. The exclusion of routine foot care would be consistent also with the practice of private insurance of excluding routine foot care when covering podiatrists' services.

The exclusion of routine foot care would apply generally to such care, including any routine foot care that might be provided by a medical doctor, but as a matter of fact medical doctors almost never provide such care. Thus the exclusion of routine foot care would not in fact be a deliberalization from present law in this respect.

The provisions of the bill would be effective for services furnished after December 31, 1966.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in *italic*, existing law in which no change is proposed is shown in roman) :

SECTIONS 1861(r) AND 1862(a) OF THE SOCIAL SECURITY ACT

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

* * * * *

Physician

(r) The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), or (2) a doctor of dentistry or of dental or oral surgery who is legally authorized to practice dentistry by the State in which he performs such

function but only with respect to (A) surgery related to the jaw or any structure contiguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone, or (3) *a doctor of podiatry or surgical chiropody, but (unless clause (1) of this subsection also applies to him) only with respect to functions which he is legally authorized to perform as such by the State in which he performs them.*

* * * * *

EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;

(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for;

(3) which are paid for directly or indirectly by a governmental entity (other than under this Act and other than under a health benefits or insurance plan established for employees of such an entity), except in such cases as the Secretary may specify;

(4) which are not provided within the United States (except for emergency inpatient hospital services furnished outside the United States under the conditions described in section 1814(f));

(5) which are required as a result of war, or off an act of war, occurring after the effective date of such individual's current coverage under such part;

(6) which constitute personal comfort items;

(7) where such expenses are for routine physical checkups, eyeglasses, or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, hearing aids or examination therefor, or immunizations;

(8) where such expenses are for orthopedic shoes or other supportive devices for the feet;

(9) where such expenses are for custodial care;

(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

(11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household; **[or]**

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth**[.]**; or

(13) *where such expenses are for routine foot care, including the removal of corns or calluses and the trimming of nails.*

The CHAIRMAN. Dr. Mowbray, we appreciate very much your bringing to us the position of your very fine association. We appreciate also your bringing to the witness table those you have with you, particularly Dr. Ed Barron of Little Rock, a longtime friend of mine, who preceded you I understand as president of the national association. Is that right?

Dr. BARRON. Right.

The CHAIRMAN. Did he immediately precede you?

Dr. MOWBRAY. Yes; this is correct. I'm sorry.

The CHAIRMAN. We had hoped to be able to correct this matter while he was president. Maybe we can do it while you are president.

Dr. MOWBRAY. Thank you.

The CHAIRMAN. You do prefer the language of the bill that we reported from the committee last year to the language which is in H.R. 5710, is that correct?

Dr. MOWBRAY. This is correct, sir.

The CHAIRMAN. You did point out the change in the bill that we reported last year.

Dr. MOWBRAY. That is right.

Dr. BARRON. Yes, sir.

The CHAIRMAN. Any questions of these very fine people?

If not, we thank you gentlemen.

Dr. MOWBRAY. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Gardner. Dr. Gardner, if you will identify yourself for our record by giving us your name, address, and capacity in which you appear we will appreciate it.

STATEMENT OF DR. LYTT I. GARDNER, NATIONAL CHAIRMAN, PHYSICIANS FORUM

Dr. GARDNER. Thank you. Mr. Chairman and members of the committee, I am Dr. Lytt I. Gardner, national chairman of the Physicians Forum and professor of pediatrics at the State University of New York, Upstate Medical Center in Syracuse.

I would like to present to you a summary of my full statement, hoping that the full statement will be included in the record.

Our organization since 1939 has tried to bring objective considerations to the problems of the extension of medical care to create, if you will, a dialectic in the Hegelian sense in the discussion of the problems of medical care. We welcome the opportunity to comment on provisions of H.R. 5710 and other matters, such as section 101, the increase in benefits for the old-age survivors and disability insurance.

We as an organization feel that good health among the aged, as among other groups, requires adequate financial resources to permit the individual to have the other attributes required for existence, so that good health naturally proceeds from there.

We favor the health insurance for the disabled, section 125, a small group statistically, but very high risk medically. We also favor section 127, the podiatrists' services, feeling that if the old people are able to ambulate they may very likely be able to keep out of bed, which we all realize has some hazards both in young age and old age.

Section 130, hospital outpatient and inpatient benefits. We favor the proposed new part C for title XVIII which provides more adequate inpatient benefits and we favor particularly the notion that those eligible for part A benefits would be entirely covered for inpatient diagnostic X-ray and laboratory procedures. We note that Senators Aiken, Mansfield, and Prouty have introduced Senate bill 110 which would further extend this concept to include not only radiologists and pathologists, but also physiatrists—these are specialists in physical medicine and rehabilitation and are not to be confused with psychiatrists—and the anesthetists as well.

The development of the new heart diseases, cancer and stroke regional programs is going to have a very great impact on medicine in this country, and it very likely will increase the total number of hospital-based specialists. We feel it is difficult to justify why the hospital-based anesthetist, internist, surgeon, otolaryngologist, and so forth should not be placed in the same category that the new part C would place the radiologist and the pathologist.

This leads us to a general consideration of the pitfalls of the laissez-faire fee-for-service concept. We feel that the notion of a nationwide fee schedule, which is gaining some cognizance in this country, using the local prevailing fees as a mode of determination of what is a proper fee, has some serious drawbacks in the future for us. In such a seller's market the only direction for fees is up. This is a serious problem in costing future medical services in the United States.

Secretary John Gardner of HEW has recently been quoted by the New York Times to have found that physicians' fees have gone up 7.8 percent in 1966, the greatest annual increase in 40 years, and this he reportedly attributed to two factors: that the number of physicians has not kept pace with the increased demand for their services, which "helped push up the price" and also evidence that medicare was not a "major factor" in the rise in doctor fees.

He made several recommendations which we approve heartily, especially those regarding the encouragement of group practice, especially prepaid practice, and to make more efficient use of equipment, personnel, and consultation. Another two of his proposals we concur with heartily: the use of Federal funds to train physicians' assistants, and to encourage doctors to use assistants for more kinds of work which would, we hope, multiply the usefulness of the physician. We also favor the plan to create a national center for health services research to help develop community health care systems.

Quality control of institutional and professional services is a problem, and one that will increase as the use of public funds for health care increases in this country. The fee-for-service concept makes it very difficult to achieve overall quality and cost control in our present institutions. We recommend that the administration of HEW direct the Health Insurance Benefits Advisory Council to set up a careful evaluation of the question of the issues of institutional and professional quality in the entire medicare program, including determination of whether the present almost total reliance on the Joint Commission on Accreditation of Hospitals is indeed in the best interests of the public.

We recommend that the following portions of section 1861(e) (8) of the Social Security Amendments of 1965 relating to requirements for hospital standards be deleted: "* * * except that such other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on Accreditation of Hospitals * * *."

We emphasize that the requirements of the joint commission are minimal ones, and there should be no prohibition of more adequate Federal standards.

The providers of service, both institutional and professional, have to finance the Joint Commission on Accreditation of Hospitals, which in turn exercises quality control on the providers of services. This could be interpreted as a situation involving conflict of interest. Perhaps the staff of the joint commission could be supplemented by staff from HEW to form a "Joint-Joint" Commission which would be less susceptible to the conflict-of-interest criticism.

Furthermore, on the problem of the quality standards for physicians under title XVIII, part B, the only standard so far is licensure,

and with the ever-increasing complexity of modern medicine in the field of nuclear biology, radiotherapy, surgery of the heart and great vessels, and so forth, it is obvious, I think, to all of us that a medical license alone is not sufficient evidence of adequate training to cope with all these specialized fields.

Elimination of deductibles. We favor the elimination of deductibles in title XVIII, part A, and part B, and prohibition of deductibles in programs set up by the States in title XIX. With the social security minimum benefit of \$44 a month, a \$50 deductible payment looms quite large, so that this not only delays treatment, but introduces excessive complications for the patient, especially regarding reimbursement procedures.

Coverage of prescription costs. We realize this is a serious problem and a very complicated one. Some older people have to choose between drugs and food. There are many older people who have maintained a sort of internal balance with certain drugs. They don't have to go to the hospital, but they do need the drugs and they may have considerable difficulty in paying for these drugs. We suggest that a reasonable initial step would be to start a program on a limited basis for the few important drugs such as insulin, digitalis, and so forth for providing drugs to the elderly in order that experience can be gained in this particularly difficult problem.

Section 220, Title II: Limitation on Federal Participation in Medical Assistance. We believe it is rather premature to place restrictions on the State programs under title XIX until they have got going. On the other hand, we don't have illusions about this type of program. We realize that this is welfare medicine with a means test, and has this disadvantage for the overall future of the development of medical care programs in this country.

As one hospital administrator mentioned to me the other day, "If they don't have coverage under part B of XVIII or can't otherwise pay their bill, then we turn them over to medicaid or welfare," so that "medicaid-or-welfare" has developed a similar bracketing and connotation, at least in New York State.

We particularly feel that section 225, the setting up of an advisory council, is worth consideration by the Congress, and we look with favor on the provisions that a majority of the membership of the council would consist of representatives of consumers.

Title III: Improvement of Child Health. That, of course, is very close to my heart as a pediatrician. I see every day in my practice the results of congenital abnormalities in children, with tragic results if they aren't corrected early. Considering that we in the United States are in 11th place in world figures for infant mortality, it is really high time that we get on with the job of providing the basic coverage for physical handicaps in children throughout the country, especially children in disadvantaged areas. Title III would do a little to help in this. The relatively modest expenditure of money would be recouped over and over again in terms of better health and effectiveness of the children and mothers reached by these measures.

In conclusion, then, the Physicians Forum would not like to see the social security legislation of 1965 with its succeeding amendments perpetuate a pattern of welfare medicine. The efforts of Secretary

Gardner and the Department of HEW to explore new and efficient methods of health care, and to encourage group practice on a prepaid premium basis meet with our enthusiastic approval. These and other programs of health care, such as national compulsory health insurance or a nationalized health service, must be thoroughly explored if we are to meet the challenges of the 21st century.

In this great country we must, to paraphrase Lincoln, disenthral ourselves of the dogmas of the past. We must cast off the chains that bind us to the 17th century "Poor Law," and divide our people into haves and have nots, into private medical care, and welfare medical care. We must act anew, and we must think anew. We must say, as did Tennyson's Ulysses:

Come my friends,
 'Tis not too late to seek a newer world.
 Push off, and sitting well in order smite
 The sounding furrows; for my purpose holds
 To sail beyond the sunset. * * *

Thank you.

(The statement referred to follows:)

STATEMENT OF LYTT I. GARDNER, M.D., NATIONAL CHAIRMAN,
 THE PHYSICIANS FORUM

SUMMARY

(1) *Title I, Sect. 101, Increase in OASDI Benefits*

Supported; reasons given as related to general support required for good health.

(2) *Title I, Sect. 125, Health Insurance for the Disabled*

Supported; medically high-risk group in great need.

(3) *Title I, Sect. 127, Podiatrists' Services*

Supported; benefits to elderly described.

(4) *Title I, Sect. 130, Hospital Outpatient and Inpatient Benefits*

New part C, Title XVIII supported. Importance of total coverage in part A, Title XVIII for x-ray and laboratory specialists' services. Problem of fees from specialists not covered by Title XVIII is discussed.

(5) *Pitfalls of Laissez-faire Fee-for-service Concept*

In sellers' market doctors fees trend rapidly upward. New recommendations of Secy. Gardner of H.E.W. regarding rising medical costs are detailed and commented on.

(6) *Quality Control of Institutional and Professional Services.*

Question is raised as to whether H.E.W. should rely totally on Joint Commission on Accreditation of Hospitals, since Joint Commission may have some conflict of interest. Recommendation to improve institutional quality control is made. Lack of quality standards for physician-specialists under Title XVIII is scored.

(7) *Elimination of Deductibles in Titles XVIII and XIX.*

This is strongly favored.

(8) *Coverage of Drug Costs in Titles XVIII and XIX*

A limited pilot program favored.

(9) *Title II, Sect. 220, Limitation on Federal Participation in XIX*

Restrictions believed to be premature. Title XIX discussed at length.

(10) *Title II, Sect. Advisory Council re. Medical Assistance*

Supported.

(11) Title III, Sections 301-303, Child and Maternal Health

Enthusiastically supported.

(12) Principles of Good Medical Care

Physicians Forum is concerned that Medicare is perpetuating welfare medicine. To meet challenges of 21st century medical care techniques that will preserve dignity of the individual are absolutely essential: new patterns such as group practice on prepaid premium or capitation basis, national compulsory health insurance or a nationalized health service must be explored.

STATEMENT

Chairman Mills and members of the committee, the statement I wish to make is in my role as National Chairman of the Physicians Forum, a national organization of physicians established in 1939 to provide a forum for the discussion of improved methods of extending medical care. To quote the constitution of the Physicians Forum adopted in 1947: "Methods for the prevention of disease and for the distribution of high quality medical care have not kept pace with the advance of medicine and the social and economic changes that have taken place. Physicians and laymen must cooperate to bring the benefits of modern medicine to all people."

My background is as a medical teacher, investigator and practitioner, devoting myself especially to genetic and biochemical abnormalities of children. I have been on the medical school faculties of the University of North Carolina, Johns Hopkins, Yale and now am Professor of Pediatrics at the State University of New York, Upstate Medical Center in Syracuse, N.Y. In 1962-63 I was president of the Society for Pediatric Research, and am on the Board of Directors of the Scientists' Institute for Public Information, the Advisory Board of the Medical Letter and the Editorial Board of the Journal of Clinical Endocrinology and Metabolism. In 1961 I was a recipient of the E. Mead Johnson Award for Pediatric Research of the American Academy of Pediatrics. Past duties have included membership on the Training Committee of the National Institute of Child Health and Human Development and on the Editorial Board of the Journal Pediatrics.

The Physicians Forum welcomes the opportunity to comment on the President's proposals for revisions in the Social Security system as outlined in H.R. 5710 and on other related matters.

TITLE I, SECT. 101, INCREASE IN OASDI BENEFITS

We favor the proposed increase in benefits for the old-age, survivors, and disability insurance. The increase in the maximum amount of earning counted for tax purposes will also make for more equitable taxation, since the present pattern of taxation tends to call upon a disproportionate percentage of the lower wage earner's income for this tax as compared with the middle and upper income groups.

The Physicians Forum supports these improvements because we recognize that good health, among the aged, as among all other groups, requires adequate financial resources to allow the individual to secure sufficient food, clothing, shelter and recreation.

TITLE I, SECT. 125, HEALTH INSURANCE FOR THE DISABLED

An important group to be covered under the Health Insurance Benefits Program are the social security disability beneficiaries under age 65, (sect. 125) a statistically small but medically high-risk group who have great need of these services.

TITLE I, SECT. 127, PODIATRISTS' SERVICES

We believe that much disability in older people could be prevented if the provisions of H.R. 5710 relating to podiatrists' services were enacted. As long as an older person is able to walk comfortably and go about his or her business on foot, there is far less opportunity for the development of the circulatory disturbances associated with excessive chair and bed existence.

TITLE I, SECT. 130, HOSPITAL OUTPATIENT AND INPATIENT BENEFITS

We are in favor of the proposed new part C for title XVIII which provides more adequate inpatient benefits for those eligible for part A benefits. This will eliminate some of the excessive complexities of the present law which requires that the physician component of x-ray and laboratory services be separated for purposes of payment, and will provide that those eligible for part A benefits will be entirely covered for inpatient diagnostic x-ray and laboratory procedures. In this regard the new part C is a much more realistic beginning for providing specialized physician services to inpatients. It should be pointed out, however, that this coverage is still very incomplete, since the specialized services of x-ray and laboratory physicians are only two items in the list of services from specialized, hospital-based physicians found in many of our medical centers.

The recent proposed title XVIII amendment of Senators Aiken, Mansfield and Prouty (S. 110) would include not only the radiologists and pathologists (laboratory specialists), but also the physiatrists (specialists in physical medicine and rehabilitation) and the anesthesiologists. It should also be recognized that the development of the Heart Disease, Cancer and Stroke Regional programs will further increase the proportionate number of hospital-center based specialists of all kinds. It is difficult to justify why the hospital-based anesthesiologists, internist, surgeon, otolaryngologist, etc. should not be placed in the same category that the new part C places the radiologist and the pathologist.

PITFALLS OF LAISSEZ-FAIRE FEE-FOR-SERVICE CONCEPT

If we continue in the traditional fee-for-service approach for these other physicians we further imbed ourselves in a financial morass from which there is no escape. The fee schedule proposed by Senators Aiken, Mansfield and Prouty (S. 110), represents a well-motivated, but basically ineffective attempt to solve the problem of rising costs of professional services. This nationwide fee schedule would vary with locality, *depending upon the prevailing fees charged outside the Social Security plan*. In such a seller's market the only direction for fees is up. We believe that no fee schedule approach will solve the problem of rising costs. Mr. John W. Gardner, Secretary of the Department of Health, Education, and Welfare, was reported in the March 1, 1967 New York Times to have found that physicians' fees had gone up 7.8 per cent in 1966, the greatest annual increase in 40 years, and more than double the usual yearly increase. He attributed this to two factors, according to the news story, : that the number of physicians has not kept pace with the increased demands for their services, which "helped push up the price"; and also the evidence that Medicare was not a "major factor" in the rise in doctor's fees. Secretary Gardner's main recommendations are quoted below :

1. A study, to be undertaken shortly by the Department of Health, Education, and Welfare to see if generic drugs—those sold by their chemical name instead of by brand—are as effective as brand-name products.

2. Making drugs safer and cheaper by having the Food and Drug Administration provide an official source of information to physicians on the efficacy and side effects of new drugs.

3. Encouraging group practice, especially prepaid practice, by physicians to make more efficient use of equipment, personnel and consultation.

4. Broadening private and public health insurance plans to include more alternative types of medical care. This would be achieved partly through model state laws that would encourage or require comprehensive health insurance coverage.

5. Reviewing the formulas for paying hospitals for Medicare and Medicaid to encourage greater hospital efficiency. Mr. Gardner said the present Medicare reimbursement plan, based on "reasonable cost," tended to maintain hospitals that were inefficient in size, plant layout, and equipment.

6. Using Federal funds to train physicians' assistants and to encourage doctors to use assistants for more kinds of work.

7. Creating a national center for health services research and development in the Department of Health, Education, and Welfare to develop community health care systems.

QUALITY CONTROL OF INSTITUTIONAL AND PROFESSIONAL SERVICES

When services are provided by physicians on a fee-for-service basis, working in institutions, overall quality and cost control present some unusual difficulties. We recommend that the administration of H.E.W. direct the Health Insurance Benefits Advisory Council to set up a careful evaluation of the question of the issues of institutional and professional quality in the entire Medicare program, including determination of whether the present almost total reliance on the Joint Commission on Accreditation of Hospitals is indeed in the best interests of the public. It is recommended that the following portion of sect. 1861(e) (8) of The Social Security Amendments of 1965 relating to requirements for hospital standards be deleted: ". . . except that such other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on Accreditation of Hospitals" We emphasize that the requirements of the Joint Commission are minimal ones, and there should be no prohibition of more adequate Federal standards.

It must be recognized that the providers of services (both institutional and professional) have to finance the Joint Commission on Accreditation of Hospitals, which in turn exercises quality control on the providers of services. This could be interpreted as a situation involving conflict of interest, especially since the hospital-based medical care of the elderly now involves such heavy expenditures of public funds to these institutions and their related professional staffs. It is our understanding that the Joint Commission presently is inadequately staffed to inspect properly and frequently enough the large numbers of hospitals and nursing homes now receiving Medicare payments in the United States. I think it a proper function of the Federal government to look into this situation to see if the public interest is being fully protected. Perhaps the staff of the Joint Commission could be supplemented by staff from H.E.W. to form a "Joint-Joint" Commission which would be less susceptible to the conflict of interest criticism.

Furthermore, is it in the best interests of the public that there are no quality standards for physicians under title XVIII part B except for licensure? (sect. 1861, (r) of the Social Security Amendments of 1965). The rapidly advancing technologies of medicine require ever-more specialized training to master the fields of nuclear biology and radiotherapy, surgery of the heart and great vessels, cardio-pulmonary physiology, organ transplantation, etc. It is obvious to all that a medical license alone is not a sufficient evidence of adequate training to cope with these or other specialized fields.

ELIMINATION OF DEDUCTIBLES IN TITLES XVIII AND XIX

Our organization strongly favors elimination of the deductible in title XVIII, parts A and B, and prohibition of deductibles in programs set up by the states under title XIX. Some patients have postponed needed care in hopes that they could make it through the year without paying the deductible sum. For a person on the minimum social security monthly benefit of \$44, a \$50 deductible payment looms quite large. This can only have adverse effects from the public health standpoint, in that the identification of disease in the elderly is delayed and inhibited.

Deductibles in the outpatient department are almost impossible from the administrative point-of-view, and are very costly to administer. Both the outpatient and the inpatient deductibles discriminate against the poorest. They may also cause delay in essential hospitalization or outpatient diagnostic procedures so that eventual therapy is ineffective, with resultant longer-term disability and overall increased medical costs.

Further, the deductible clause introduces excessive complications for the patient, especially regarding reimbursement procedures. This is particularly true if the patient makes the mistake of crossing a state line in seeking medical care, a likely possibility in our mobile society. A member of the Physicians Forum in Philadelphia sent me the following newspaper story, which speaks for itself in telling the frustrating story of a lady in Penns Grove, N.J., reprinted from the Philadelphia (Pa.) *Bulletin* :

"FRUSTRATING ROAD AHEAD FOR PATIENT WITH DOCTORS' BILLS FROM 2 STATES

"(By David M. Cleary of *The Bulletin Staff*)

"Question: My mother has Medicare A and B, and by the time she entered a hospital in December, she had paid \$40 in doctor bills since July. She was a clinic patient in a Philadelphia hospital, so the hospital's doctors took care of her, except for two consultants who were called in. They charged \$35. Then the family doctor came to see her twice after she got home, charging \$14. She paid all these bills, plus the \$18 for six months of Part B coverage, making a total of \$107, which is hard on a Social Security income of \$70 a month.

"Couldn't the hospital do the paperwork for the two doctors it called in? And how can my mother get the rest of the money back?

"Mrs. A.B., Penns Grove, N.J.

"Answer: Your mother's procedure for claiming reimbursement is more complex than average, because she dealt with doctors in both Pennsylvania and New Jersey. The reimbursement system is set up according to where the services were rendered, not where the patient lives.

"First of all, Medicare Part A paid the hospital for the services of its salaried doctors, so you don't get any bills from them. But the hospital doesn't act for other doctors who attended you while there; their bills come under Part B.

"Of the \$107 total, only \$89 represents doctors' bills, and only \$31.20 of that is recoverable, since your mother must pay the first \$50 and 20 percent of the remaining \$39 herself.

"Even getting the \$31.20 is likely to be frustrating and lengthy. She must send one claim to Pennsylvania Blue Shield in Camp Hill, attaching the \$35 in receipts from the two Pennsylvania doctors, and another to Prudential Insurance Co., Box 6500, Millville, N.J. attaching the \$54 worth of receipted bills from New Jersey doctors.

"Each of those paying agents will query Social Security headquarters in Baltimore about your mother's status, and if they query at about the same time, both will be advised that she hasn't paid her first \$50 yet. The upshot is likely to be a letter from Camp Hill saying she isn't entitled to anything and a check from Millville for only \$3.20 because all Millville will know any thing about is the \$54 paid to New Jersey doctors.

"Avoiding that problem takes time and patience, but it can be done. If your mother will send a claim to Millville first, then apply to Camp Hill after she receives the payment from Millville, the electronic brain in Baltimore will okay the second payment from Camp Hill, amounting to 80 percent of \$35, or \$28.

"If all this seems hopelessly complicated, your only recourse appears to be to complain to members of Congress. They enacted the law, and they are the people with power to simplify it."

COVERAGE OF PRESCRIPTION DRUG COSTS IN TITLES XVIII AND XIX

The cost of drugs is a serious problem. The President recognized this in his recent message on Aid for the Aged when he observed that Medicare does not cover prescription drugs for a patient outside the hospital, and directed an immediate study of the cost of drugs. Some older people have to choose between drugs and food. A member of the Physicians Forum in Maryland has written me the following suggestions:

"As a next step, both Titles XVIII and XIX should cover drugs, that is, there should be mandatory coverage of drugs. Title XVIII should include drug coverage under Part B, simply because for many patients, the cost of drugs is the most important single item in their medical care. Many aged persons, fortunately, remain in homeostasis [proper internal balance] with very occasional physician's visits, taking a considerable amount of drugs on a year-round basis—the diabetic, asthmatic, the arthritic, and patients with Parkinsonian disease, etc. Some of these patients do not have enough physician's visits during the course of the year to equal the coinsurance feature of fifty dollars.

"Under Title XIX, a number of states have started their programs without including drugs for the relief clients covered under the program. * * * Patients in such states have to go to the County authorities, to private agencies, literally to scrounge for drugs."

The mounting problem of the costs of drugs to elderly people on limited income is one that must be met. That the problem is being faced in the Congress is indicated by the bill introduced by Representative Boggs of this Committee (H.R. 276) which would include prescribed drugs under part B of title XVIII. In the bill of Senators Aiken, Mansfield and Prouty (S. 110) there is also a provision for supporting the costs of certain "qualified drugs," these to be determined by a National Formulary Committee.

This is undoubtedly a complicated issue—how best to provide prescription drugs to the elderly patient, and at the same time maintain quality control of the drugs and the most advantageous cost for the government. Perhaps a reasonable initial step would be to start a program on a limited basis with a few important drugs, such as insulin, digitalis, etc., so that needed experience can be gained.

TITLE II, SECT. 220. LIMITATION ON FEDERAL PARTICIPATION IN MEDICAL ASSISTANCE

Our organization feels that it is rather premature to place restrictions on the state programs under Title XIX before they have really had a chance to get unlimbered. On the other hand we have no illusions about the basically unhealthy nature of this type of program: it is welfare medicine with a means test.

The Physicians Forum prepared a position paper on the general aspects of Title XIX which is detailed below:

"STATEMENT ON TITLE XIX OF PUBLIC LAW 89-97

"This amendment to the Social Security Act passed by Congress in 1965 relates to Federal grants to States for medical assistance programs. It is popularly referred to as 'Medicaid' (or 'Medical') and is to be distinguished from Title XVIII ('Medicare') which provides for the financing of health insurance for the aged.

"MAIN PROVISIONS

"1. The concept of medical indigency, applied by Congress to the 65-and-over age group in the Kerr-Mills legislation of 1960, is extended to include, in addition, all recipients of federally-aided public assistance programs; namely, dependent children and their families, the blind and the permanently and totally disabled plus all other medically needy children. This means that States may secure Federal monies toward defraying the costs of medical care for individuals and families meeting the definitions of the federally-eligible groups whether or not they require cash benefits for maintenance, if their income and resources are not sufficient to meet their medical care costs.

"2. States or territorial jurisdictions to be eligible for Federal aid must have programs approved by the Secretary of Health, Education, and Welfare. Guidelines for these include the following:

"(1) In developing the medical assistance aspects of its programs, a State must not reduce aid or assistance under its existing categorical plans.

"(2) A program must eventually apply equally to all eligible groups within the State and include a minimum of five specific medical care services: inpatient and outpatient hospital care, skilled nursing home care (for adults only), physicians' services, laboratory and X-ray services; the amount, scope, duration and methods of rendering such services to be determined by the State.

"(3) Eligibility requirements must take into consideration only income and resources available to the recipients, exclude adult children from responsibility for the medical care costs of their aged parents, and omit any specified period of residency in the State. Each State sets its own means test.

"(4) Determination of eligibility is the responsibility of the State agency charged with such determination under the Old Age Assistance provisions of the Social Security Act.

"(5) There must be equal coverage and eligibility requirements by 1975 for that portion of a State's population not included in the federally-aided categories, with the necessary financing for these non-categorical groups to be borne by the State alone.

"GOOD FEATURES

"1. Increased Federal money will be available to the States to help finance medical care services.

"2. Medical assistance programs for all groups within a State will be uniform in content and financing provisions.

"3. Publicly financed medical care services will be available to a larger section of the population including those unable to meet their medical care costs but otherwise able to maintain themselves.

"4. Eligibility requirements are liberalized not only with respect to the inclusion of the medically indigent, but by the elimination both of residency requirements and of responsibility of children for their parents' medical care expenses.

"5. States may not reduce existing aid programs in order to develop medical assistance programs.

"BAD FEATURES

"1. This is enabling legislation: a State may or may not choose to participate.

"2. This is not a national program: each participating State or territorial jurisdiction writes its own medical care program and eligibility requirements according to very minimal guidelines.

"3. This is welfare medicine: a means test is a prerequisite to eligibility for medical care services financed under this program.

"4. The quality of the medical care to be made available is uncertain: no significant safeguards or standards are written into the law.

"5. Federal aid is not available to the States for the medically indigent who are in the 21-64 age groups and do not fall into any of the designated federally-aided categories.

"So much for the law itself as enacted by Congress. What have been the experiences to-date and what are the prospects under the legislation as it now stands?

"As of November 30, 1966 twenty-five States and Puerto Rico and the Virgin Islands had programs in operation with the possibility that three more plans might be implemented or approved before the end of the year. For the remaining 24 jurisdictions no programs were in the offing. In the deep south, only Louisiana had a program in operation.

"Although this seems to represent faster progress than occurred with the Kerr-Mills program, and Title XIX, itself, contains improvements over Kerr-Mills, one cannot help but see analogies between the two which bode no good for a goal of good quality, comprehensive, personalized care for all people in the Nation. Since Federal aid requires that the State allocate matching funds, albeit based on formulas favoring the poorer States, we again may have the situation of the wealthier States coming up with the more adequate programs and getting a disproportionate share of Federal funds. There still may be States that won't bother to formulate programs. After six years of operation, seven jurisdictions out of 54 still had no programs of medical assistance to the aged under Kerr-Mills.

"And what about the welfare aspects of this program? Although the intent of Congress was to eliminate some of the undesirable aspects of a means test and the liberalizing elements represent important advances, a means test is still a prerequisite to entitlement to services. Even more significant, perhaps, is the mandatory designation of the welfare agency as the agency to make the determination of eligibility. Many people, in need of medical care, will refuse to submit to this indignity. And keeping in mind the dual system of medical care long prevalent in this country, private care and charity medicine, this method of entitlement to services not only perpetuates two classes of medical care but actually extends charity-type medicine to more people.

"Paradoxically, even a poor law can be weakened further, so that the efforts of men of good will may be needed not only to improve it but even to preserve it as is. The history and nature of the New York State program constitute a case in point. When title XIX became law, New York State already had a medical assistance program for the medically indigent of all population groups with income ceilings for entitlement relatively high. With the prospects of Federal aid to supplement what it was already committed for, it felt able to raise this ceiling to a figure more nearly approaching cost of living estimates for the State. New York came up with a figure of \$6000 (net income after taxes and medical insurance premiums), for a family of four, and continued to cover all groups.

"The New York program produced a vitriolic attack from conservative forces in the State as well as in Congress. It went back to the State legislature almost

immediately, and a deductible feature for out-of-hospital expenses was introduced. Restrictions, ostensible to reduce the cost to the Federal government, were considered by the House Ways and Means Committee but were not acted on by the 89th Congress. Activity along these lines in the 90th Congress can be expected.

"CONCLUSION"

"Title XIX is a program that has the potential of bringing medical care to certain additional groups in the population, mainly the poor. It is a limited program at best and contains many undesirable features. Its potential is further limited by economic and political forces within each State. With all this, its limited benefits must still be protected from attack and, where possible, improved and extended."

TITLE II, SECT. 225 ADVISORY COUNCIL

Our organization supports the proposal to create an Advisory Council on the administration and policies of medical assistance, and looks with favor on the provision that a majority of the membership of the council would consist of representatives of consumers. It is suggested that at least two representatives of consumers would be physicians associated with consumer groups.

TITLE III, IMPROVEMENT OF CHILD HEALTH

I cannot overemphasize the importance of support of Title III relating to improvement of child health. I see every day in my own practice the long-term effects of congenital abnormalities in children, whether caused by genetic or environmental factors. Often the difference between normal childhood and adult life and a tragic, blighted existence can be ascribed to early diagnosis and treatment of defects found at birth. Sect. 301 receives our enthusiastic support for early case finding and treatment of handicapping conditions of children.

A similar principle applies to the proposal to support special projects to improve dental health in childhood (sect. 302) and to increase support for maternity and infant care projects (sect. 303).

It should be cause for national concern that this nation, supposedly the most affluent culture ever to exist, ranks 11th in infant mortality, behind nations such as Norway, Sweden and Britain. This is almost certainly due to the vast inequities which exist in our heterogeneous peoples scattered over a continent, and to the historical forces which have shaped the ethnic and economic composition of our population. It is not defensible to permit the cultural and economic deprivation of disadvantaged areas of this country to take such a toll of life and health in the young. The United States is the only Western industrial nation without a national allowance for children, and the various states' programs for needy children are very spotty. Title III will at least do a little to help some of those children who have physical handicaps. The relatively modest expenditures will be recouped over and over again in terms of better health and effectiveness of the children and mothers reached by these measures.

Principles of Good Medical Care

The Physicians Forum believes that everyone is entitled to good medical care as a fundamental right. Society must accept responsibility for assuring comprehensive, personalized, high quality medical care to everyone. This includes all needed preventive, diagnostic, therapeutic and rehabilitative health services. Physicians should play a major role in helping society to fulfill this responsibility.

To this end the Physicians Forum affirms the following principles of good medical care:

1. A single class of medical care for all
2. Elimination of financial barriers
3. Teamwork
4. Total care for the total person
5. Adequate health manpower
6. Quest for excellence.

A Single Class of Medical Care for All.—Throughout the country several classes of medical care exist side by side. The prevailing basis for segregating patients is income status. Those who cannot afford medical care are segregated into public ward and clinic services. The charity medicine which they receive is generally piecemeal, inadequate, and provided with scant concern for the dignity of the individual. Furthermore, in many private practices and medical institutions

in all parts of the country, more or less overt racial discrimination is superimposed on economic segregation. These practices fail to meet social needs and desirable standards of medical ethics, and represent a denial of democratic rights. All such segregation and discrimination must be eliminated through appropriate legislation and administrative policies, vigorously enforced. This objective must be furthered by educational and other efforts to promote personal commitment on the part of health personnel to a single class of medical care for all.

Elimination of financial barriers.—Federal financial participation is necessary to assure to all persons continuous and complete coverage of medical-care costs from job to job, place to place, and decade to decade. Such a universal program must cover the full range of medical care services from health education, screening, and preventive care, to treatment and rehabilitation, including physicians' and dentists' care, institutional services, drugs, and necessary supporting services. To yield the greatest return for the medical care dollar, the payment program must provide service benefits and must be rationally organized. Deductible and co-insurance features are undesirable as they are likely to delay treatment and actually increase both cost and duration of disability.

Teamwork.—With the increasing complexities of medicine, teamwork has become a virtual necessity. Many types of functional relationships among the providers of health services have evolved. Experience indicates that formally-constituted arrangements often are most effective and satisfying. These may be illustrated by three examples:

1. The full-time staffs of hospitals and medical groups which offer opportunities to improve the quality of patient care and stimulate professional growth.

2. Regional programs which coordinate a teaching medical center with neighboring hospitals to offer the most advanced and specialized medical techniques to the entire population, urban and rural.

3. The multi-disciplinary rehabilitation team which facilitates maximum physical, social, and psychological recovery.

Less than optimal medical care occurs too often when practitioners are functionally isolated and health institutions are functionally independent.

Total care for the total person.—The current fragmentation of medical care frustrates many physicians and other health professionals in their efforts to establish sound patient-physician relationships and to provide a unified approach to their patients' physical and emotional needs. To replace the general practitioner of the past who could provide personalized medical attention before the current era of specialization, a well-trained personal physician should provide preventive as well as therapeutic care, with continuity, and with concern for the physical and emotional well-being of each family member. These physicians should be supported and supplemented by a complete range of specialized services to promote health and provide prompt treatment of all medical and psychiatric disabilities. Continuity and personalized care must not be compromised by size or administrative complexity. There is need for greater consideration of the social and psychological aspects of patient care.

Adequate health manpower.—There is a great and increasing shortage of physicians and other health personnel. Society must provide full tuition and financial support to induce qualified individuals to become physicians, dentists, nurses, medical technicians and other health personnel. Discrimination against racial minorities, women, and other special groups must be eliminated from education and training in the health fields and from opportunities for advancement. Salaries of nurses and other poorly paid health personnel should be made attractive and competitive with the rewards of other professions. There must be improved utilization of physicians and other health personnel through imaginative but realistic work analyses and the development of new staffing patterns so that each type of health worker can function to the maximum of his capabilities.

Quest for excellence.—The quest for excellence requires an atmosphere of intellectual searching. Continuing experimentation is essential in the search for ever better medical care. New findings and skills must be neither accepted nor rejected uncritically. Prime regard for patient welfare, high standards, adequate training, and scientific research are basic essentials for good medical care. Clinical practice must be subjected to rational evaluation; physicians must be accountable through formal mechanisms both to colleagues and to patients. Resources must be allocated for demonstration projects, for quality studies, and for recognition of high competence and unusual contributions.

Requirements for Adequate Medical Care.—These fundamentals of medical care planning recognize the essential and complementary roles of the individual health worker, of hospitals and other local health services, and of the Federal government. Comprehensive high quality medical care requires:

1. the personal commitment of each health worker to this goal
2. the initiative and flexibility of local organizations to meet diverse local conditions
3. assurance by the Federal government of equal opportunity for all through maintenance of standards and through financial aid for special problems requiring national action.

This last responsibility cannot be fulfilled with the proportion of the nation's wealth now devoted to health. The proportion must be increased substantially, perhaps even doubled. Finally, it must be recognized that medical care is not the total answer and may not even be the major part of the answer to improvement of the health of the people. Much poor health, disease and disability are the result of the total environment in which we live. Wars, slums, environmental pollution and hazards, racial discrimination, exploitation of human labor and other social ills, are, in a fundamental sense, appropriate concerns of health personnel. We physicians should recognize that our responsibility must extend beyond the problems of individual patient care to the broader issues of public policy.

Conclusion

The Physicians Forum would not like to see the Medicare legislation of 1965, with its succeeding amendments, perpetuate a pattern of welfare medicine. The efforts of Secretary Gardner and the Department of Health, Education and Welfare to explore new and efficient methods of health care, and to encourage group practice on a prepaid premium basis meet with our enthusiastic approval. These, and other patterns of health care, such as national compulsory health insurance or a nationalized health service, must be thoroughly explored if we are to meet the challenges of the 21st century.

In this great country we must, to paraphrase Lincoln, disenthral ourselves of the dogmas of the past. We must cast off the chains that bind us to the 17th century Poor Law, and divide our people into haves and have nots, into private medical care and welfare medical care. We must act anew, and we must think anew. We must say, as did Tennyson's Ulysses:

"Come my friends,
 "'Tis not too late to seek a newer world.
 "Push off, and sitting well in order smite
 "The sounding furrows; for my purpose holds
 "To sail beyond the sunset. . . ."

Mr. BURKE (presiding). Thank you very much, Dr. Gardner.

Are there any questions? There being no questions and no further witnesses, the testimony having been completed for the day, the committee will adjourn until 10 a.m. tomorrow morning when we will take up another subject matter.

The committee stands adjourned.

(Whereupon, at 12:30 p.m., the committee adjourned on the social security hearing until 10 a.m. Thursday, March 16, 1967.)

PRESIDENT'S PROPOSALS FOR REVISION IN THE SOCIAL SECURITY SYSTEM

THURSDAY, MARCH 16, 1967

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met, pursuant to notice, at 10 a.m., in the committee room, Longworth House Office Building, Hon. Wilbur D. Mills (chairman of the committee) presiding.

The CHAIRMAN. The committee will please be in order.

Our first witness this morning is our colleague from Minnesota, the Honorable Donald M. Fraser. Mr. Fraser, we appreciate your being with us today and you are recognized, sir.

STATEMENT OF HON. DONALD M. FRASER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. FRASER. Thank you very much, Mr. Chairman and members of the committee. I am pleased to have the opportunity of presenting information in support of H.R. 5710, the Social Security Amendments of 1967. An identical bill has been introduced in my name to demonstrate my strong endorsement for broad increases in benefits and coverage under the social security laws.

SECTION 101. INCREASE IN BENEFITS

In Minnesota we had 403,673 persons receiving monthly benefit payments under social security at the end of 1965. That year a total of \$349,786,000 was paid to them.

The bill the committee is considering would increase those payments about \$80 million a year. In the Twin Cities where my district is located there would be a \$30 million increase in benefits for the recipients in Hennepin and Ramsey County.

I know from personal contact with these retired people that this increase is badly needed. And the children of these retired people are solidly in favor of raising the present starvation levels to more adequate levels. The generation of working men and women will look forward to their own retirement with less misgiving if decent schedules of benefits can be adopted by the 90th Congress.

One of the most active and knowledgeable groups of retired citizens in my district is the Legislative Goals Senior Citizens Study Club. Their experience shows that an even greater increase than appears in H.R. 5710 is necessary. They recommend minimums of \$150 for a single person and \$200 for a couple.

Another large and effective group in Minneapolis is the Old Timers Union Club AFL-CIO. They have written to me giving full endorsement to the increases in H.R. 5710. I am sure that every other Member of Congress has similar groups who know from firsthand experience that the present benefits are far too meager.

SECTION 104. INDIVIDUALS AGE 72

The increases proposed for individuals age 72 and over who lack the minimum number of quarters in covered employment are sensible improvements.

However, I would like to suggest one further change. We should permit former State and local public employees over age 72 to receive the benefits we have authorized under the so-called Prouty amendment. Under existing law persons over 72 are required to deduct State and local government pensions from benefits under the Prouty amendment.

Thus, most do not qualify for assistance under the Prouty amendment.

It seems to me only fair that this small social security benefit should be made available to former public employees even though they are now receiving a retirement benefit under their governmental system.

In Minneapolis a handful of retired city employees who are over 72 receive very small checks because they entered the program when salaries were very low.

As you know, the Prouty amendment is only a temporary provision to bring benefits now to persons over 72 or who reach 72 in the next few years and have less than the normal requirement of "quarters of coverage" under social security. The Prouty amendment is designed so that this group will become smaller and smaller each year.

I certainly hope that this can be one of the improvements to H.R. 5710 that the committee will consider.

SECTION 125. HEALTH INSURANCE FOR THE DISABLED

Totally and permanently disabled are another group who need medicare coverage. And for exactly the same reasons as Congress adopted medicare for the elderly over a year ago.

Those reasons are:

1. The disabled are without earning power to pay their own hospital and medical bills, just as the elderly.
2. They are likely to have higher and more frequent bills than the average person.
3. They are probably unable to obtain private insurance coverage—and if they can, the cost is likely to be prohibitive.

In Minnesota there are 400,000 persons now eligible for medicare and another 11,500 disabled workers who would be eligible for medicare if H.R. 5710 passes. The estimated annual cost for hospital insurance for this 11,500 would be \$2,500,000.

SECTION 132 (NEW). REIMBURSEMENT FOR MEDICARE PATIENTS'
TRANSPORTATION TO THERAPY CENTER

Mr. Chairman and members of the committee, this section deals with a matter of some great concern to me and to people in my State. I hope the committee can look at this carefully. There is a provision in the present medicare law which leads to inefficient use of professional medical personnel. The law doesn't allow transportation expense to be paid for a patient to visit a hospital or rehabilitation center for therapeutic care. The law tends to encourage a therapist to make individual trips to treat a single patient in his home.

Ten members of Congress joined me last year in supporting a change in the law. They were Congressmen James A. Byrne, Ronald B. Cameron, John H. Dent, Leonard Farbstein, Bernard F. Grabowski, Jacob H. Gilbert, Thomas P. O'Neill, Claude Pepper, Benjamin S. Rosenthal, and Fernard J. St Germain.

The problem is well explained in a letter I received recently from the head of the Department of Physical Medicine and Rehabilitation at the University of Minnesota.

I am writing again about my concern that the provision under medicare to send therapists into the home without equal provision for transportation for patients to the hospital for outpatient therapy will result in a disastrous depletion of hospital personnel.

Our recent survey of facilities and therapists in this area indicates that we have approximately one-fourth as many therapists as we need. If we are going to provide the most extensive treatment, then we must utilize these therapists efficiently.

A therapist can treat approximately 30 percent as many patients if she travels to the home as she can working in a rehabilitation center or hospital physical therapy department, and even then is very limited in the kinds of things she can do. Her actual usefulness, therefore, is between 10 and 15 percent of what it would be in an organized center.

At the meeting of the American Rehabilitation Foundation Expert Medical Committee this fall, we discussed this problem of provision of rehabilitation therapy to patients in their homes. There were physiatrists from every part of the United States, New York, Philadelphia, Georgia, Texas, Connecticut, Washington, Minnesota, and Michigan.

All of these men have been in physical medicine and rehabilitation for many years and are leaders in the field. All of them are interested in developing the best possible kinds of services and have had experience with virtually every kind of service which has been tried.

In discussing this problem, not a single example could be found or cited where a home rehabilitation therapy service had been developed which provided anywhere near as good therapy as outpatient therapy, and always at a much greater cost.

The evidence is clear, the physiatrists who have been on the spot and testing these systems find that administration of rehabilitation therapy in the home is ineffective and inefficient use of personnel.

Frederic J. Kottke, M.D., Professor and Head, Department of Physical Medicine and Rehabilitation.

This same viewpoint has been expressed by the American Congress of Physical Medicine and Rehabilitation.

The hospital director at the Veterans' Administration hospital in Ann Arbor, Mich., has endorsed this change on the basis of his experience. He states:

The health manpower shortage is increasing in all disciplines. Travel of health personnel to the patient is wasteful and should not normally be necessary. Con-

centration of patients in hospitals or clinics allows one therapist to see many patients so that many profit from his skill.

For these reasons I believe the committee may want to consider an amendment that would delete from section 1861(m) (7) of the Social Security Act the words: "but not including transportation of the individual in connection with any such item or service."

SECTION 201. EARNINGS EXEMPTION FOR PUBLIC ASSISTANCE RECIPIENTS

One of the most important features of H.R. 5710 is the work incentive provision in section 201.

In Minneapolis the mothers on AFDC have organized a league which is part social action and part political action. I know from meeting with them and talking to professional caseworkers that part-time work can be a real boost to the self-respect and well being of children and the mothers.

Let me read to you from a letter I received recently from a mother who receives public assistance. She has been able to retain some of her earnings from part-time work because Congress allowed earnings exemptions in both the Elementary and Secondary Education Act and Economic Opportunity Act. She writes as follows:

As an A.D.C. mother I would like for you to know personally what the "Work Incentive Program" means to me.

I am now working as a Neighborhood Development Aide for the Citizens Community Center. This is my first real work experience as I married young and started a family young. After being on A.D.C. for four years which I have truly appreciated I was glad to be able to go to work part time. This gave me a chance to give my children a few extras such as musical instruments, better clothes, and my teenagers an allowance so they can participate in more activities such as Y.M.C.A., dances, sports, et cetera.

My family is proud of the fact that I am working and now that my children are all in school, I would very much like training so I can go on to full time work and become financially independent and to be able to further help my children with their education.

I am very thankful for the experience of working at the Center and how I have learned to work and grow.

In Minnesota there are 14,660 families and 42,055 children receiving AFDC help. The average maintenance grant to a family is \$175.28. The change proposed by section 201 would have an enormous effect on these families and these children. I believe that the exemption of \$85 plus half of all earned above \$85 would be an even better incentive than the amount of H.R. 5710. Both the aid to the blind program and the economic opportunity Act have this higher exemption and it works very well.

SECTION 209 (NEW). FEDERAL SHARING OF THE COST OF GENERAL ASSISTANCE

Another improvement of our public assistance laws that should receive your consideration at this time is the conversion of local programs of general relief into a categorical aid program under our welfare laws with Federal and State Governments sharing the cost.

For too long we have expected local villages and cities to handle all poor-relief that did not come within such major federally aided categories as old-age assistance, aid to families with dependent chil-

dren, and aid to the blind and disabled. This has resulted in very low standards for general assistance and places too great a burden on the limited tax resources of local government.

The Advisory Council on Public Welfare reported last June in the excellent booklet, "Having the Power, We Have the Duty," some of the deficiencies of the present welfare system. They listed the following as the types of poor persons who are not being helped by any federally aided public assistance program:

Most needy adults under 65 years of age who are unemployed or unable to earn an adequate income;

Most needy children living with both parents or someone other than a close relative;

Needy disabled adults who are not both permanently and totally disabled;

Many children in need because of the unemployment of a parent;

Needy otherwise eligible persons who have not resided in a particular State for a specified period of years;

Needy mothers who are employable but for whom no jobs are available; and

Persons rapidly losing their vision but not yet blind enough to qualify for assistance for the blind.

These are the groups that could be aided by the amendment I suggest.

Last year I asked the Department of Health, Education, and Welfare for comments on the possible cost of this program. Commissioner Ellen Winston estimated the cost at \$500 million.

It seems to me that the time has arrived when we must upgrade the assistance programs being administered throughout the country. Matching funds from the Federal Government and uniform standards for eligibility are badly needed.

SECTION 238 (NEW). FEDERAL SHARING OF THE COST OF STATE CHILD WELFARE SERVICES

Last year I was one of the members who gave support to the proposal of our late colleague, the Honorable John E. Fogarty, for Federal sharing of State child welfare services. Congressman James A. Burke and others are carrying forward this idea in the 90th Congress.

Minnesota's State commissioner of public welfare has termed this proposal the single most important piece of welfare legislation Congress could enact this year. Experts in my district—with private agencies as well as with government—are very much in favor of this proposal. I hope the committee will make it a part of H.R. 5710.

SECTION 401. SOCIAL WORK MANPOWER AND TRAINING

The University of Minnesota in my district has the only graduate school of social work in Minnesota. The requests for graduates far exceeds the ability of the school to give graduate training. John C. Kidneigh, director of the school, reports that agencies from every part of the country write asking for graduates to employ.

Of the 120 graduate students now enrolled 73 are residents of Minnesota and 47 are from out of State. But another 100 Minnesota residents have to go out of State to get their social work training.

Section 401 would set up a program that would make it possible for the University of Minnesota to expand its graduate training program to help fill the pressing need for more skilled people. Funds for adding to the faculty and for providing student traineeships are badly needed.

Earl J. Beatt, executive director of Family and Children's Service in Minneapolis makes this comment typical of professionals faced with the problem of hiring qualified staffs.

Legislation such as the Social Work Manpower Training Act, which would help to increase needed manpower in the field of social welfare, is a crying need if we are to truly organize, structure and provide many of the programs which have already been recommended through legislation of Congress.

SECTIONS 504 AND 505. SPECIAL EXEMPTIONS AT AGE 65 AND RETIREMENT INCOME DEDUCTION

The changes in the Internal Revenue Code will be welcomed by many of our older taxpayers. Much of the complexity and inequity in treatment of retired persons will be eliminated.

One group who have been asking for modification of tax treatment are the retired State and local government workers. I have been in close touch with Mr. W. F. Doerr, executive secretary of the Minneapolis Municipal Employees Retirement Board.

Municipal employees of the city of Minneapolis and its related boards and commissions have since 1920 contributed a fixed portion of their pay to a retirement fund which, when supplemented by the municipal government, provides an allowance not later than age 65.

Under Minnesota State law the members of this fund are exempted from participation under social security. There is no choice for them on this matter.

Under present Federal law the portion which they have contributed to their own retirement allowance is tax paid; the portion contributed by the employer becomes taxable income. This is an added burden by contrast with employer contributions to social security. This burden is particularly onerous because it falls in the later years of retirement after tax paid personal contributions are paid out and when purchasing power of their fixed dollar income is eroding.

If H.R. 5710 becomes law, section 504 and its special tax exemption of \$2,300 for single taxpayers over 65 would provide a fair standard for offsetting the tax inequality of non-social security retirees.

Of the 2,375 former Minneapolis city employees receiving retirement allowances at the end of 1965, about 75 percent received less than \$2,300 per year. This means that section 504 will provide tax relief to these retired employees who need it most.

Section 505 is also desirable for these social security exempt public employees under age 65. It provides them the same retirement income deduction as those receiving social security or railroad retirement benefit.

In the Minneapolis system, for example, about 25 percent or 642 retired employees are under the age of 65. This includes about 60

who are disabled and 47 who are survivors of employees who died while in service. It is particularly important that this group also receive tax relief.

SUMMARY

I certainly feel that H.R. 5710 is an excellent bill. This Congress will have strengthened our social security, welfare, and tax laws immeasurably if we enact it into law.

The additional suggestions for Federal sharing of the costs of child welfare services and of general assistance and of the revision in the medicare law relating to the payment of transportation costs for persons who need rehabilitation therapy are logical next steps in a strengthened public welfare program.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Fraser, for your very fine statement. We appreciate your coming to the committee. Are there any questions of Mr. Fraser?

Mr. BUSH. Mr. Chairman, I have one.

The CHAIRMAN. Yes, sir. Mr. Bush.

Mr. BUSH. Mr. Fraser—a very quick one. With respect to the amendments that you propose, have you had a chance to put a price tag on these benefits and if so how would you propose that this be paid for?

Mr. FRASER. The price tag on bringing general assistance or what we call poor relief into a categorical aid program, a Federal and State aided program, would cost around \$500 million, and of course that figure is in my statement. That would have to be financed out of general revenue. There is no special tax or source from which that could be paid.

The amendment that deals with the payment for transportation for patients who need therapy care, who ought to be able to go to a hospital or therapy center instead of having the doctor or therapist go to them, I do not have a price tag on.

My expectation would be that this amendment might save the Government money. To the extent that medical personnel are more efficiently used it would seem to me that the costs would tend to be lower rather than higher.

In other words, if a therapist—and they are really in short supply—has to travel out to a home to provide some kind of therapy, therapy which will be inadequate at best, it is going to be more expensive than if we pay the cost of the patient to come down to see the doctor, or the therapist, or the physiatrists, or whatever at a hospital or therapy center.

I don't think that this would be a significant cost item. I think that amendment could be made without any problem.

Mr. BUSH. But on this Federal sharing in the cost of general assistance, you would propose to just increase the taxes further to pay for this.

Mr. FRASER. If I may make an observation about that, the heaviest burden for poor relief in the United States tends to fall on the core or central cities in our metropolitan areas. The poor for a variety of reasons tend to migrate to the central cities, but of course largely

because that is where housing is available. This also happens to be where there is the most acute tax distress in the United States, the local tax problem. You may not share that view, but this is certainly true in my State. We have severe financial problems in the city of Minneapolis because our tax resources, which are limited to property tax, are inadequate to meet the burdens.

One of the very important reasons from my point of view for putting poor relief, which is locally financed in our area, under a federally aided program, would be to help provide some tax relief to these core or central cities, but it would also have the other two important effects. It would even out the tax burden. You get areas of high unemployment, for example, where after unemployment compensation runs out, then the poor relief loads begin to grow. This happens in the northern part of Minnesota in the iron ore area, on the iron range, and this is a very heavy burden on local government. This program would help distribute that burden. More importantly than all, perhaps, it would tend to upgrade standards because in many communities the poor relief standards are very low.

These are all, I think, important reasons why this ought to be looked at very seriously. There is no reason why the four categorical groups now should be the only people aided by the Federal Government. It seems to me that those who are generally in need of relief should be aided.

Mr. BUSH. I think that is right, but as you get into adding to these programs you have a whole other group that we aren't doing much for and that is the young people, and their families living on a \$6,000 income. They have kids with horrible expensive braces they have to put on their teeth. They have to put them through school. They pay a \$600 tax on a \$6,000 income. Older people on a \$6,000 income under proposed law would pay nothing and they have medicare going for them. I think many of the things that you recommend are worthy and I know that many people on this side of this committee and the chairman would probably feel that many of these things are worthwhile.

The only gnawing problem I have is how do we pay for it and if we are going to do all these things who is going to look after this other group, the young people.

I come from a metropolitan area and it would be tempting to stick the people in the country by doing more Federal things in the city, but I am just not sure this is equitable.

However, I appreciate your statement and certainly it is a lot of food for thought.

Mr. FRASER. If I may just add one comment, I noticed many of our colleagues both in the Congress and in the political arena have been calling for a turnback of Federal revenues to State and local government.

One of the most efficient ways to do this in a very specific way which would be enormously useful would be to pick up a part of the cost of poor relief.

Mr. BUSH. Of course that is discriminatory.

Mr. FRASER. This would get money back very directly and would have these other important side effects.

Mr. BUSH. But in my opinion it would not be altogether equitable because you come from a city and so do I, and it would be great for us, but there are a lot of people who feel there are some poverty problems in the rural population.

All I can say is though you might like it and though I might like it because we are both city Congressmen, I submit there are plenty of people in the Congress and in the country who wouldn't like it, so I am just not sure that it is altogether equitable and of course one of the things this committee must concern itself with is the equity of taxation.

Mr. COLLIER. Will the gentleman yield just a minute?

Mr. BUSH. Yes, sir.

Mr. COLLIER. Just to make an observation on this problem of relief to larger cities, and indeed we all understand what the problem is, it seems to me we must also remember during the last 3 years, to be exact, no segment of our national picture has received more assistance from the Federal Government than this group. I am not suggesting it is necessarily wrong, but some 19 new programs to provide relief to the big cities and its tax problem have been enacted into law.

At some place there is a breaking point. I think we all ought to understand that. In that same light let me suggest that the President, as you well know, has submitted a new budget. There is no provision in it for this kind of program, and Congress is going to be told repeatedly this year to hold the line on the President's budget. I just don't know how you are going to get 3 pounds of waste out of a pound of fat.

Mr. FRASER. Mr. Chairman, may I just respond briefly.

I recognize the revenue problems this year and I happen to think that this is one of the programs that ought to have a fairly high priority. There are a lot of programs that our Government is going to be financing and they all ought to be looked at rather carefully.

May I just say, though, on your other point about all these programs, all of them are really only aimed to help people wherever they are found whether in the central cities or in the rural areas. The Elementary and Secondary Education Act helps the poor child wherever he lives. The poverty program helps the poor people wherever they live.

While it is true there is an aggregation of these people in the metropolitan areas, I think that is a matter of happenstance and not one of design on anybody's part.

Mr. COLLIER. I am sure of that. I made this comment not as criticism, but rather as an observation, one that we should be cognizant of in legislating in the future if we wish to stay within the realm of fiscal reason as to what can and cannot be done, desirable as these things might be.

Mr. FRASER. If I may comment, we are spending about \$70 or \$80 million a day now in Vietnam. Hopefully, some day that will come to a close.

Mr. COLLIER. Amen.

Mr. FRASER. At that time there will be released to be turned back either to the taxpayer or to State and local government, or through federally sponsored programs, a considerable amount of money, and if you in your wisdom don't think that this kind of program should be

adopted this year, I hope at least you will be thinking about it when the money is available.

The CHAIRMAN. Any further questions of Mr. Fraser?

If not, again we thank you, sir.

Mr. FRASER. Thank you very much, Mr. Chairman.

The CHAIRMAN. Our next witness today is the Honorable E. Y. Berry from the State of South Dakota. You are recognized, sir.

STATEMENT OF HON. E. Y. BERRY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH DAKOTA

Mr. BERRY. Mr. Chairman, I greatly appreciate the opportunity to present my views on pending social security legislation to this committee. As author of a bill which would provide immediate benefit increases of 8 percent, an automatic escalator clause to increase benefits to keep them in line with cost-of-living increases, and a provision for automatic tax increases to cover any new benefit costs, I am deeply aware of the importance of this legislation. I would like to make three main points for this committee.

1. Social security programs have gone far beyond their original scope and cost to the point where the payroll taxes are a significant burden. This means, of course, that the program is far from a quasi-insurance program which was the original intention. While we are assisting many elderly and disabled persons, we are on the borderline of creating a quasi-welfare program where each American is forced to participate in this program. Estimates regarding the amount which a person might save if he did not have to contribute to the program range as high as \$65,000 for a young man who might save each year until he is 65 years of age. The committee must realize the impact of this program, particularly in light of the proposals for increases.

2. Secondly, I would like to point out a feature in my bill which I have included to bring attention to the fact that social security is far from a "free ride." Whenever the Secretary of the Treasury, in conjunction with the Secretary of Health, Education, and Welfare, determines that the cost-of-living escalations will not generate enough new taxes to cover the required higher benefits, payroll taxes must be immediately and automatically increased.

3. Lastly, I would urge the committee to give full consideration to each of the alternative proposals which are pending in the field of improvements to the social security program. Hopefully, the constructive parts of many bills can be incorporated into a solid, workable formula best geared to our needs.

The CHAIRMAN. Are there any questions? If not, thank you, Mr. Berry, for being with us today.

We are pleased to have our colleague from California, the Honorable Jerome R. Waldie, with us this morning. You are recognized.

STATEMENT OF HON. JEROME R. WALDIE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WALDIE. Mr. Chairman, I introduced H.R. 4283 on January 31 of this year to correct what I feel is an inequity in the Social Security Act to cover the case of one of my constituents and others throughout the United States.

H.R. 4283 will amend title II of the Social Security Act to permit a woman to become entitled to full wife's insurance benefits after attaining age 65 even though she became entitled to reduced old-age insurance benefits (or disability insurance benefits) before attaining that age.

The case in point is one where my constituent retired at the age of 69, having paid in toward social security 4 years beyond the qualified age of 65. At that time his wife's age was 66. As the social security law stands now the wife is entitled to 50 percent of his social security benefits, even though she might not have worked at any time. However, in this case the wife contributed toward social security and had chosen to retire at 62. Thus, the Social Security Administration states that the wife is not entitled to 50 percent of the husband's benefits, but only to such benefits earned by herself. If the wife had never worked, she would receive 50 percent of her husband's social security benefits in the normal course of events.

I appreciate the opportunity of having incorporated in the record of these hearings on the President's proposals for revision of the social security system my statement in substantiation of my introduction of H.R. 4283.

The CHAIRMAN. We appreciate your coming to the committee, Mr. Waldie. Are there any questions? There are none. Thank you.

Dr. Fry. Dr. Franklin Clark Fry, president of the Lutheran Church in America.

Dr. Fry, we appreciate having you with us this morning. If you will identify yourself by giving us your name, address, and capacity in which you appear we will be glad to recognize you for 10 minutes.

STATEMENT OF DR. FRANKLIN CLARK FRY, PRESIDENT, LUTHERAN CHURCH IN AMERICA

Dr. FRY. Thank you.

The CHAIRMAN. Pardon me, Dr. Fry, just a minute. Mr. Rhodes.

Mr. RHODES. Mr. Chairman, I believe that we all feel to be highly honored by the appearance of Dr. Fry here this morning. Dr. Fry is not only president of the Lutheran Church in America, but he is also the chairman of the Executive Committee of the World Council of Churches, and I am pleased that Dr. Fry has come to testify and support legislation which I have introduced to improve the coverage of ministers under social security.

Dr. FRY. Thank you. Mr. Chairman, I assure you that I know that the honor is mine to appear before this distinguished committee.

The CHAIRMAN. Thank you, sir.

Dr. FRY. Mr. Chairman and members of the committee, my name is Franklin Clark Fry. I am president of the Lutheran Church in America which, for the record, has a membership of 3.2 million persons. I am appearing today to testify on behalf of our church's board of pensions through which it provides pensions, death benefits, and health benefits to some 6,500 ministers and their dependents.

I appreciate this opportunity to testify on social security and in so doing, to state my strong support, and that of the Board of Pensions of the Lutheran Church in America, for H.R. 5940 introduced by Mr. Rhodes of this committee.

The effect of this bill would be that all ministerial service would be automatically covered under social security unless an individual minister elects to be exempt on grounds of conscientious objection to public or governmental insurance. That, in my opinion, would place such coverage on a much more adequate and equitable basis than now prevails.

When social security coverage for ministers was first proposed in the mid-1950's, the administration recommended an employee-employee basis similar to that applicable to lay employees of churches. That proposal met with vigorous opposition arising out of many denominations. Some stated that they believed that ministers ought not to be regarded as "employees." Others wanted to avoid a situation in which a minister who opposed coverage on grounds of conscience because of the "separation of church and state" principle would be compulsorily covered if he accepted a call to a church that had previously elected coverage for its minister.

Accordingly, a revised basis was adopted by Congress that served to satisfy almost all, if not completely all, parties. Under the basis which is currently in effect, each minister makes an irrevocable election whether to participate, and if he opts to participate, this election is on the self-employed basis.

In order to safeguard the system against antiselection, the minister must make the election within 2 years after ordination (or, for existing ministers, within 2 years of the date when coverage was first possible). Because in the past, many ministers for one reason or another, failed to meet the deadline, it has been extended three times by legislation.

At present, however, coverage is available only for newly ordained ministers.

Although this coverage basis has worked out reasonably well, it has not been wholly satisfactory. In the aggregate, about 75 percent of all ministers have availed themselves of the opportunity of social security coverage. That percentage however, needs some interpretation.

It is somewhat misleading, because the proportion of those electing coverage has been about 95 percent among older ministers, but only about 60 percent for younger ones.

As a result, over the long run, the proportion of ministers who are covered may well drop to only 50 percent.

Why are so comparatively few of the younger ministers covered under social security? Various surveys have been made, which indicate that two major reasons exist for failing to elect coverage. The first reason is financial—a belief that a better-protection buy can be obtained elsewhere, or a desire to spend less money currently.

The second reason is political—a personal dislike of social security and other governmentally sponsored welfare programs.

Undoubtedly, too, many young ministers have not elected coverage within the 2-year period required because they have not carefully looked ahead at their long-distant future needs for social security protection. Only a small minority have not elected coverage on grounds of conscience.

The revised basis in H.R. 5940 is premised on the underlying principle that social security coverage is desirable for ministers just as it is

for the employed members of their congregations who are compulsorily covered.

In my view, the financial and political arguments which some ministers advance against being covered have no validity as a basis for the exemption of ministers from compulsory coverage, since these same arguments would apply equally to lay members of congregations who are not allowed to elect out of coverage on those grounds.

Nor can ministers argue validly for special treatment on grounds of religious conscience. In any event, the revised coverage basis contained in the bill meets this point fully.

The bill provides that all ministers are to be covered unless they apply for exemption on the grounds of conscience based on religious principles. Coverage would, of course, continue automatically for those who are now covered by virtue of having previously filed a waiver.

For ministers not now covered by social security and for those ordained in the future, coverage would be automatic unless, within a 2-year period, they file an application for exemption. This procedure as to exemption follows the precedent of the so-called Amish provision in the 1965 act. The present exemption of ministers and members of religious orders who have taken a vow of poverty would be continued.

The proposed basis should have general appeal since it accomplishes what was originally intended—to give the special privilege of exemption from social security only to those who are conscientiously opposed thereto on religious grounds. The result would be to assure much-needed social security protection to the vast majority of ministers.

The fact that ministers must continue to pay the self-employed rate need not be a serious deterrent. Many congregations are now indirectly paying part or all of the minister's social security contribution through an increase in his salary intended for that purpose.

Furthermore, Congress has recognized the financial burden of the self-employed under the original "1½ times the employee rate" basis by setting a 7-percent ceiling on the self-employed rate for the cash benefits and by having the self-employed pay the same rate as the employee for hospital benefits.

I hope and anticipate that there will be little, if any, opposition to the proposal contained in H.R. 5940. I am informed that copies of the bill have been furnished to the proper church authorities operating all the denominational pension plans.

Undoubtedly, the committee will be given the views of many of them. I trust that the comments will all be favorable to Mr. Rhodes' bill, and I hope that the committee will incorporate it in any social security legislation that is reported out.

Such action will, in my judgment, be highly beneficial to ministers and their families by providing them with an excellent package of retirement, disability, survivor and health benefits, through the combination of social security and denominational pension plans.

It is my view and that of the board of pensions of the Lutheran Church in America, for which I speak, that this measure will strengthen the social security program and is in the national interest.

Thank you, sir.

The CHAIRMAN. Dr. Fry, we appreciate very much your bringing to the committee your thoughts with respect to this matter and that of your board.

Any questions of Dr. Fry? Mr. Schneebeli.

Mr. SCHNEEBELI. Dr. Fry, does it seem a little inequitable to you that ministers and the farmers and self-employed generally until sometime in the 1970's will be paying 50 percent more than high salaried employees such as the president of General Motors and even after 1972 will still be paying 40 percent more than the employee group? Does this seem to you to be fair?

Dr. FRY. Really I have never been greatly troubled by the percentage charged to the president of General Motors since I hadn't been aware of it, to tell you the truth.

Mr. SCHNEEBELI. I say ministers pay 50 percent more into social security than does the president of General Motors.

Dr. FRY. They do?

Mr. SCHNEEBELI. Yes. Does this seem a little unfair to you?

Dr. FRY. Does the fact that they are on a self-employed basis seem unfair to me?

Mr. SCHNEEBELI. The fact that they have to pay 50 percent into social security to get the same benefits.

Dr. FRY. In order to be on the self-employed basis they have to pay 50 percent more and I would say that it is well worth paying the 50 percent more to be on the self-employed basis.

Mr. SCHNEEBELI. You mean merely to have that privilege of being on a self-employed basis?

Dr. FRY. Because there are various principles involved. Allusion has been made in my brief statement to the separation of church-and-state issue. I think the church-and-state issue is not involved at all if ministers are treated on a self-employed basis. I think it could very well be considered involved if they were taxed as employees and their employing congregation were taxed.

Mr. SCHNEEBELI. That is all.

The CHAIRMAN. Mr. Collier.

Mr. COLLIER. Dr. Fry, just one question. You say one of the advantages of being self-employed of course is that you are in no manner conflicting with the so-called separation of church and state?

Now, if you have a Government program, such as this is, wherein it would be compulsory, do you not construe this in some respect to remove this advantage that you refer to of separation of church and state?

Because it becomes compulsory, then you have a little different situation it seems to me than when it is voluntary.

Dr. FRY. This bill does not, of course, provide compulsory coverage for ministers who object on grounds of conscience. I would very strongly express my personal view, speaking now only for F. C. Fry, that it is highly desirable for ministers to be on a self-employed basis in order to avoid the situation in which the Government would be taxing a congregation of believers for the services of a minister.

I was one of those who in the first stages of this discussion in the midfifties opposed the coverage of ministers in social security. I gave

an address to the Church Pensions Conference in that direction in those days because of the church-state issue, but as soon as the self-employed basis was suggested by the Congress I embraced it heartily because I think that eliminates any possible implication of church-state issues in this matter.

Mr. COLLIER. Even though it is compulsory and there is no ready choice on the part of ministers.

Dr. FRY. I find no infringement on the rights of the church.

Mr. COLLIER. Thank you.

Dr. FRY. The infringement would begin, let me repeat, only if the State gets to the point of taxing congregations for the privilege of being served in a spiritual way.

The CHAIRMAN. Mr. Battin.

Mr. BATTIN. Dr. Fry, let me compliment you on your concise statement and your responses to questions so far to the Members of Congress. I was interested on page 2 of your statement that why some of the younger ministers did not want to go into the program was, for the first reason, financial.

Dr. FRY. That is right.

Mr. BATTIN. And a belief that they could buy better protection elsewhere. Based on that, has the church done anything as far as papers or discussions trying to overcome this or any other objection to it?

Dr. FRY. Yes, sir. Speaking in behalf of the boards of pensions of the Lutheran Church in America, we work very hard to overcome such objection. There has been constant advocacy on the part of the board in personal conference and in immeasurable correspondence to try to persuade people to come into social security.

Mr. BATTIN. I know your Mr. Lund and I know his power of persuasion. How will this affect the present pensions that are set up by the church?

Dr. FRY. Our whole pension system, which is I suppose at least average for Christian denominations, contemplates a man being in social security, and it disturbs us greatly that many men may come to the end of their service without adequate income because of failure to opt into social security.

That, incidentally, would be a source of embarrassment to the church at that stage because they might come back to the church with a compassionate plea, which we could hardly grant in fairness to those who have contributed all along for their social security benefits.

We believe that for a man to get something that would be a reasonable retirement allowance it will be necessary to combine the income from social security with the income from our pension plan which is adjusted to fit social security at every point.

Mr. BATTIN. I see that the church retirement pension program does contemplate supplementation from either a person's own private plan or social security.

Dr. FRY. It does definitely. There is no pretension on the part of the church plan that it will provide enough for a man to live really comfortably.

The CHAIRMAN. Mr. Ullman.

Mr. ULLMAN. Dr. Fry, I appreciate your constructive statement. I know you are speaking for the Board of Pensions of the Lutheran

Church in America, but it has been indicated here that you are also active on the Council of Churches, is that right?

Dr. FRY. That was mentioned, yes, by Mr. Rhodes, and it is the truth. I, however, did not premise my statement on that.

Mr. ULLMAN. No, I understand that, but in your experience with the other churches I know that this issue must have come up.

Dr. FRY. Oh, yes.

Mr. ULLMAN. Do you know anything about the opinion of the ministers in the other various churches?

Dr. FRY. I believe I do, sir. Let me say in clarification that my official connection is with the World Council of Churches, not with the National Council, which are quite separate entities and, of course, pensions are not a subject normally before the World Council of Churches, but I do know of personal knowledge that the church pension authorities of the various denominations who gather together in the Church Pensions Conference regularly are unanimously or all but unanimously in favor of this movement.

Other denominations find themselves in the same situation and the same predicament in which we find ourselves.

Mr. ULLMAN. I am glad to hear that. I think this is important for this committee to know the feelings of the other churches and the other boards of pensions on this matter.

Dr. FRY. Of course. We are just a small fraction. For that reason I made reference to the fact that our argument is being furnished to the other church authorities and of course Mr. Rhodes' bill certainly is in their hands and we anticipate that they also will be filing statements of one kind or another in many cases, although some of them may think that my appearance here represents them too, which I do not myself presume to do.

Mr. ULLMAN. Yes. You have made a very fine case and I am very much intrigued with your solution to the problem and I would hope that we could resolve it.

Dr. FRY. Thank you.

Mr. ULLMAN. Thank you.

The CHAIRMAN. Any further questions?

Thank you again, Doctor.

Dr. FRY. You have been very courteous, sir.

The CHAIRMAN. Thank you, sir. Our next witness, Dr. Ralph Wedgwood, will be introduced by our colleague from Washington, the Honorable Brock Adams. We appreciate having you with us this morning, Mr. Adams, and you are recognized.

STATEMENT OF HON. BROCK ADAMS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. ADAMS. Thank you, Mr. Chairman. It is a great pleasure, Mr. Chairman and members of the committee, to introduce Dr. Ralph Wedgwood on behalf of myself and Congressman Pelly. Dr. Wedgwood is the head of the Pediatrics Department of the University of Washington which is located in Seattle, but this morning he comes to you as a member of the American Academy of Pediatrics, as the president of the Association of Medical School Pediatric Department

Chairmen, who are the heads of the departments of pediatrics throughout the United States, on behalf of the Society for Pediatrics Research and on behalf of the Association of the Schools of Pediatrics.

In other words, he covers the broad spectrum of children's medicine, and this morning, Mr. Chairman and members of the committee, I have asked him to summarize his statement so that you might question him because he is going to speak to the subject that there were some questions on earlier; namely, infant mortality and the crisis in manpower that has developed among the doctors and allied health professions that are handling children's problems, so I give you Dr. Wedgwood. Thank you.

The CHAIRMAN. We appreciate your coming to the committee, Mr. Adams, and we appreciate you, Dr. Wedgwood, being here, and you are recognized, sir. If you do summarize your statement do so with the full knowledge that your entire statement and the materials appended to it will be made a part of the record.

STATEMENT OF DR. RALPH WEDGWOOD ON BEHALF OF THE ASSOCIATION OF MEDICAL SCHOOL PEDIATRIC DEPARTMENT CHAIRMEN, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN PEDIATRIC SOCIETY, AND THE SOCIETY FOR PEDIATRIC RESEARCH

Dr. WEDGWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. You are recognized.

Dr. WEDGWOOD. Mr. Chairman and members of the committee, I am greatly honored and appreciative of the opportunity to appear before you. I think that the statement I make can be considered to represent the opinion of pediatrics in the United States.

The CHAIRMAN. Incidentally, we appreciate very much your bringing together in one statement the views of the many groups that are listed in support of your views.

Dr. WEDGWOOD. Thank you, Mr. Chairman. We specifically wish to support sections of H.R. 5710 in title III, sections 303, 305, and 306, and lend general support to those sections designated in title II, part 3, sections 235, and 237, and title III, sections 301, 302, and 304.

In summarizing I would like to make certain highlights first concerning the state of child health in the Nation. I think it is true that we have little cause to be proud of the state of child health in our Nation today. The health survey of 1963-64 indicated that over half of those children under the age of 6 and over two-thirds of those children between the ages of 6 and 16 had not seen a physician in the year prior to the survey.

The high rejection rates for disability at induction centers for selective service is another indicator. And the results of the physical examinations for Operation Headstart further identify the poor state of child health.

Of specific concern perhaps might be the appallingly high infant mortality rates in our Nation. The infant mortality rates in our Nation are widely varied. In some sections which can be identified by poverty, by young mothers, by high birth rates, and by high prematurity rates, the infant mortality figures are three times those of the

national average and four times or more those of the more fortunate segments of society.

In the 10 years between 1954 and 1963 other nations, not all as affluent as ours, decreased their infant mortality rates by 25, 30, and 40 percent, the United States by only 5 percent. The infant mortality rates are, I believe, a national disgrace and, indeed, the state of child health is scarcely concordant with either our high standards of living or our knowledge excellence in medical science.

You gentlemen have passed in the past few years extraordinarily fine legislation to attempt to ameliorate the state of child health in the Nation and I think we all have admiration for your efforts on its behalf, but I would like to turn my attention to those who must provide the child health services.

The child health manpower crisis: In the attachment, page A-4 of my statement, I have a table which indicates the ratio between physicians providing child health services and the child population in the United States with projections to 1980.

The ratio between the years 1940 and 1960 dropped from 336 to 146. If current trends continue, by 1980 the ratio will have dropped to 68 child health physicians per 100,000 of children in our population, a fivefold decrease from that existing before the war; and this decrease in the face of the fact that even at the present ratio we consider the provision of child health to be inadequate.

From these calculations one can estimate that to maintain the current ratios by 1980 we will need to train an additional 59,000 physicians, more than half of the output of all of the medical schools in the United States today.

Now, it is manifestly impossible to fill this manpower gap solely with physicians. We must have reorganization and increasing attention to professionalization of provision of health care for children. The pediatric departments in the United States are involved in providing the education for pediatricians, child health physicians, the general practitioners or family physicians, and for the child health education of all of the other medical specialists that provide child health services and in part for the training of the allied health professions that also provide such services.

For this reason we have been looking at the ability of the pediatric departments in the Nation to respond to this challenge to provide the manpower to meet the needs of children today and, gentlemen, the pediatric departments are seriously concerned with their possible inability to respond to this challenge.

They lack facilities, they lack manpower, and they lack funds to fulfill this need. We are attempting to derive the necessary data through an inventory of departments to substantiate the needs for manpower training. Preliminary data indicate that possibly only one in 10 departments of the 90 in the United States are strong enough and have sufficient flexibility to really man new programs or to innovate creative new techniques for the provision of comprehensive community child health care. Half are perhaps strong enough for existing training function.

The remainder are weak and would have serious difficulty. Indeed some have serious difficulty in holding their heads above water at the

present time. The situation is extremely serious and I urge you not to underestimate it. I believe that the situation is made even more acute by recent legislation in the areas of heart, cancer, and stroke, the regional medical program, and in implementation of medicare for the aged because such programs are pre-empting attention, space, and matching funds within the schools of medicine and are drawing emphasis away from the areas of child health care.

For this reason if we are to preserve the training potential of the pediatric departments, who currently train the majority of child health physicians and family physicians for child health within the United States, we need to find some way to support them, to strengthen them, so that they can accomplish their job.

The associations which I represent today have made resolutions and recommendations which are summarized in my statement on page 3 and which I would like to amplify.

First, we feel, to strengthen and expand clinical training programs to balance the research effort which has occurred in medical schools, that funds need to be directly allocated to medical schools for departments of pediatrics for the purposes of strengthening and expanding clinical training programs for the provision of personnel for comprehensive community child health care.

Obviously a formula matching basis would be appropriate.

Second, to increase the numbers and quality of pediatricians and child health physicians and to emphasize the specific qualities needed for comprehensive child health care that we should find some means of funding what are known as residency training or clinical training programs for physicians, and such are incorporated in section 305 of title III of H.R. 5710.

Finally, the lag period between the initiation of a program to train physicians and the delivery of physicians for the consumer market is long. To provide appropriate training we are in desperate need of appropriate facilities of teaching and research in innovative techniques for the provision of coordinated community child health care, and we strongly recommend consideration of funding of such facilities.

Specifically, title III, section 305, broadens the language of the Social Security Act, section 516, title V, which would allow funding for residency training and we support it fully.

Section 303 extends, expands, and increases, authorization for the maternal and infant care programs and in doing so would provide the opportunity for institutions of higher learning to participate in these programs and so strengthen their teaching and clinical training.

Title III, section 306, broadens the language of the authorization to extend the range of health care research, which is crucially needed to find the types of manpower that will be necessary to provide good child health care for the children of the Nation, and we support it fully.

The remaining amendments to title V pertinent to child health are for general improvement of child health in the Nation and would receive our general support.

Accordingly, Mr. Chairman, we, therefore, urge the approval of these amendments and their appropriate funding to meet the needs of child health, for while these amendments are not in themselves a com-

plete or sufficient solution to the crisis in child health manpower training, they will significantly increase the numbers of persons being trained and we feel represent a very major legislative advance. We believe approval of these amendments and indeed implementation of the other resolutions I have described is amply justified by the current critical child health manpower shortage and the very urgent public need.

I thank you.

(The statement referred to follows:)

STATEMENT OF RALPH J. WEDGWOOD, M.D., FELLOW, AMERICAN ACADEMY OF PEDIATRICS, PRESIDENT, ASSOCIATION OF MEDICAL SCHOOL PEDIATRIC DEPARTMENT CHAIRMEN

I am grateful for the opportunity to appear before the Committee on Ways and Means of the House of Representatives.

My name is Ralph J. Wedgwood. I live at 3717 41st Avenue N.E., Seattle, Washington, 98105. I am Professor and Chairman of the Department of Pediatrics at the University of Washington School of Medicine, Seattle, Washington. I am also President of the Association of Medical School Pediatric Department Chairmen, and a Fellow of the American Academy of Pediatrics.

ORGANIZATIONS REPRESENTED

I have been designated to represent both the Association of Medical School Pediatric Department Chairmen and the American Academy of Pediatrics. The Association of Medical School Pediatric Department Chairmen has as membership the chairmen of all medical school pediatric departments in the United States. The American Academy of Pediatrics has as membership approximately ninety-six hundred pediatricians certified by the American Board of Pediatrics and includes the majority of pediatricians practicing within the United States.

The statement therefore is on behalf of both those who have the responsibility for teaching and training in children's medicine, at undergraduate and graduate level, of family physicians, pediatricians and allied health professions, and in addition those who have responsibility for providing child health care—the practicing pediatricians. I append as attachments A and B, statements concerning child health, manpower and manpower training from both organizations, and statements of the general objectives and membership of the two organizations.

This statement is to support specifically the proposed amendments to Title V of the Social Security Act in Bill H.R. 5710, designated in Title III, Sections 303, 305, and 306. The statement also lends general endorsement to those sections designated in Title II, Part 3, Sections 235 and 237, and Title III, Sections 301, 302, and 304. We believe these sections, which pertain to child health care, can significantly improve the health of children thus: by making health care more available, by support of health care research for the development of innovative techniques, and by support to increase training of child health care personnel to meet our current critical manpower crisis.

The organizations which I represent believe that these amendments represent one of the steps required to provide the health manpower to meet the present public need.

We consider that the critical child health manpower shortage is currently the crucial issue in any consideration of meeting our child health care needs.

BACKGROUND

We are greatly concerned with the state of child health in our Nation—concerns explicitly voiced also by President Johnson in his Special Message to Congress on Children and Youth. The President stated, “. . . our public health record for children gives us little cause for complacency. . . .” The excessively high infant mortality rates in the United States, for example, are discordant with our acknowledged excellence in medical science and our high standard of living. They are a National disgrace. Additional information on the poor state of child health is given in attachment A, page A-3.

As the President further noted, "Our whole society pays a toll for the unhealthy and crippled children who go without medical care. . . ."

These are our concerns as educators of child health physicians and allied professionals, and as providers of such health services.

We are additionally concerned with the serious, indeed critical, manpower crisis for personnel to provide comprehensive community child health care. The child health manpower crisis is detailed in attachment A, pages A-3 to A-5. To fill the manpower gap, reorganization and innovation in the provision of child health services and the development of more and different types of child health personnel to multiply the effectiveness of pediatricians in the provision of health care to children are clearly needed. We fully endorse the development of a variety of new and different techniques to extend health care to all children. It is also, however, equally clear that whatever innovations occur, whatever changes are made, we must also in the immediate future improve and expand the training of pediatricians in order to increase physician manpower for this important goal.

The pediatric departments are concerned that they may be unable to expand their programs to increase the numbers of professionals to be trained. They lack funds, facilities and personnel. Indeed, the serious difficulties of pediatric departments (which are described in attachment A, pages A-5 and A-6) should not be underestimated. A great many pediatric departments are already overextended in their duties. Only a few departments are sufficiently strong to man major new programs for innovative techniques of extended and expanded training in comprehensive community child health care. Many departments are so insufficiently supported as to make it impossible for them, in spite of their concern and serious desire, to contribute in the way that they would wish to this important goal.

These concerns are also shared by the American Academy of Pediatrics. Evidence of such interest is reflected by the continuing examination of pediatric training begun over fifteen years ago, and identified in the cooperative study of Pediatric Research, Education and Practice (1964-66), and by the Pediatric Manpower Training Project which is currently conducting an inventory of pediatric department training resources.

The information available leaves little doubt that the situation concerning pediatric manpower training resources is very serious, and that urgent action is needed to strengthen these resources so that the needed increased numbers of child health professionals can be trained to fill the manpower gap.

RECOMMENDATIONS

Reviewing these critical issues, both organizations have independently approved position statements which, while slightly different in phraseology, are similar in content. The individual recommendations of the two organizations are provided in attachment A, pages A-6 and A-7, and attachment B, pages B-1 and B-2. The recommendations can be summarized as:

1. Study of the expanding manpower needs for improvement of children's health services so that appropriate recommendations can be made to increase effectiveness.
2. Support of clinical residency training programs to increase the numbers of adequately trained physicians (and allied health professions) needed to provide child health services.
3. Support for pediatric departments to enable them to strengthen and expand their clinical training programs; to encourage innovation in techniques for the provision of child health care and to develop needed leadership personnel for comprehensive community child health care programs.
4. Support for construction of needed teaching and research facilities for comprehensive community child health care; facilities are currently inadequate for this purpose.
5. Development of a variety of approaches for multiplying the effectiveness of pediatricians in the delivery of comprehensive child health care services through new types of child health personnel.

SUPPORT FOR H.R. 5710

This bill to amend the Social Security Act contains several sections which should improve child health care. The amendments would represent one step in the implementation of the recommendations of both organizations.

Title III, Section 305, by broadening the language of the present Section 516 of Title V would allow expansion of residency and related training programs, and thereby will increase the numbers and improve the training of pediatricians and other child health personnel. The changes would encourage training in new techniques and enable departments to develop leadership personnel for comprehensive community child health care programs. The changes would allow support for departments of pediatrics to increase the numbers of physicians (and allied health professions) being trained; it would strengthen weak departments in an important manner and would change emphasis in strong departments.

Title II, Section 303, would extend, expand and increase the authorization for Maternal and Infant Care programs initiated in 1966. These programs are beginning to improve both the infant mortality rates and the training of child health personnel by providing demonstration programs of coordinated and exemplary care. Subsection (a), extending and increasing the authorization, is of critical importance for continuation of these programs.

Subsection (b) is equally important; it would extend participation in such programs to institutions of higher learning and provide departments of medical schools and allied health professions support for exemplary care, thereby improving clinical teaching. The extension in subsection (b) (2) to include high risk infants would provide additional means to reduce post-natal infant mortality and morbidity rates by support of health costs for infants in appropriate intensive care (and premature) units. Such support will also strengthen and expand clinical training in this important area of child health.

Title III, Section 306, increases authorization under Section 533 and broadens the language of the authorization to extend the range of health care research. Such changes will result in better application of knowledge and manpower to health services for mothers and children, and will provide needed opportunities for innovation to meet the child health manpower crisis.

The remaining amendments to Title V, incorporated in H.R. 5710 under Title II, Part 3, Sections 235 and 237, and Title III, Sections 301, 302 and 304 would receive our general support since they provide means for expanding care, training and research for the varieties of allied professionals required for comprehensive child health care.

SUMMARY

Accordingly, we therefore urge the approval of these amendments and their appropriate funding to meet the needs of child health. For while these amendments are not in themselves a complete or sufficient solution to the problems of child health manpower training, they will significantly increase the numbers of persons being trained and represent a major legislative advance.

We believe approval of these amendments is amply justified by the current critical child health manpower shortage and the present urgent public need.

ASSOCIATION OF MEDICAL PEDIATRIC DEPARTMENT CHAIRMEN

STATEMENT

The Association clearly recognizes the poor state of child health in our Nation and heartily supports the increasing emphasis on comprehensive community child health care. The Association also clearly recognizes the need for reorganization of child health services and endorses strongly the development of new types of child health personnel to multiply the effectiveness of Pediatricians in the provision of comprehensive community child health care.

However, at the same time, the Association equally clearly recognizes that there is a serious manpower crisis of personnel to provide the comprehensive community child health care; this manpower crisis represents an acute and urgent situation.

The Association fully recognizes the importance of committing Departmental resources for the training of increased personnel for comprehensive community child health care services. But, it is quite evident that all are concerned with the ability of Pediatric Departments generally to extend and expand training and service roles. In almost every instance, capability for such expansion is hampered or made virtually impossible by lack of funds, space, and faculty.

Concern has also been expressed that because currently most Pediatric Departments are already over extended in their duties, Departmental expansion for the provision of comprehensive community child health care service might seriously

jeopardize the teaching of present students and postdoctorals which is just beginning to be brought up to adequate standards.

In 1966 the Association passed five resolutions, which were reconfirmed in 1967.

RESOLUTIONS

1. That a Commission, sponsored by the Federal Government, be appointed to study and make recommendations concerning the expanding manpower needs for improved children's health services.

2. That for the training of increased numbers of more adequately trained physicians to participate in various specialty areas of pediatrics, including comprehensive community child health care programs, we recommend direct Federal financial support for pediatric residency programs.

3. In order to develop comprehensive community child health care training programs, that legislation be enacted to provide Federal funding for construction of urgently needed teaching and research facilities to support these functions.

4. That direct Federal financial support be provided to Departments of Pediatrics, to enable these Departments to strengthen and expand their clinical training programs; such support to encourage innovation in techniques for the provisions of child health care and to develop the needed leadership personnel for programs of comprehensive community child health care.

A special case is justified for such support by the present public need.

5. That we endorse the development of a variety of approaches for multiplying the effectiveness of pediatricians in comprehensive community health care by developing new types of child health personnel.

THE ASSOCIATION

The Association of Medical School Pediatric Department Chairmen was formed in 1961 and formally organized in 1964. Membership includes the department chairmen of every medical school in the United States. The purpose of the Association is "... to foster education and research in the field of child health and human development". By virtue of their administrative position the members of the Association have the responsibility for teaching pediatrics to every medical student in the U.S. They also have direct responsibility for the pediatric residency training of about 70% of the graduates of U.S. medical schools who will become practicing pediatricians, and including indirect responsibility, for about 85% of such individuals. They have, in addition, the responsibility for teaching pediatrics to a large number of interns and residents who will become family physicians. If current trends continue and the recommendation of the Millis Commission ("The Graduate Education of Physicians"; The Report of the Citizens' Commission on Graduate Medical Education, of the American Medical Association—August 1, 1966) to consider internship and graduate training as a continuum of medical student training, these responsibilities will increase to include virtually all pediatricians and family physicians. The department chairmen similarly have responsibility for the continuing education of these physicians, for the pediatric education of other medical specialists and for education in child health for a large number of allied health professionals, including nurses, social workers, educators, etc.

The Association can therefore be considered as representing those who have the major responsibility for teaching child health in the United States.

The last two annual meetings have been devoted entirely to discussion of comprehensive community child health care, to the manpower shortage, to the response of departments of pediatrics to meet the increased numbers of pediatricians and family physicians needed to provide health services, to reorganization of health services and innovation through the development of new types of child health personnel, and to the impact of public health policy, expectations and legislation on the training of child health personnel.

THE STATE OF HEALTH OF CHILDREN

The Association is deeply concerned with the state of health of the nation's children. President Johnson has stated (Special Message to Congress on Children and Youth, Feb. 8, 1967): "... our public health record for children gives us little cause for complacency. . . . Our whole society pays a toll for the unhealthy and crippled children who go without medical care..."

Examples of this matter are innumerable. The National Health Survey of 1963-64 (Public Health Service Publication No. 1000, Series 10, No. 19, Washington, D.C.; U.S. Government Printing Office, 1965) showed that 55% of those under 6 years of age and 69% of those between 6 and 16 years had not had a regular examination by a physician in the year prior to survey. The high rejection rates for disability reported by Selective Service and the high incidence of correctable defects found through examination of children in the Head Start program also identify the fact that children are not receiving the health services requisite to allow them to fulfill their potential. A particularly appalling example can also be found in the extraordinarily high infant mortality rates found in certain segments of our population. Infant mortality rates in these areas (which are identified by poverty, young mothers, high birth rates, and high prematurity rates) are often three times higher than the national average, and four times higher than those of the more fortunate population groups, or countries such as Sweden. High infant mortality is directly associated with high infant morbidity. Premature infants and other infants similarly afflicted have a higher incidence of mental retardation and handicapping conditions. Many of these conditions are preventable, correctable, or can be ameliorated by modern medical knowledge.

These infant mortality rates are a National disgrace; and indeed the state of health of children is scarcely concordant with either our high standard of living, or our acknowledged excellence in medical science.

Physician manpower for child health services

Year:	Number of children (millions)	Number of physicians (thousands)		Child health physicians per 100,000 children
		General practitioners	Pediatricians	
1930.....	36	112	1	314
1940.....	33	109	2	336
1950.....	41	95	4	242
1960.....	56	74	8	146
1970.....	63	55	12	106
1980.....	75	35	16	68

NOTE.—Figures derived from "Statistical Abstract of the United States, 1964," U.S. Department of Commerce, Bureau of the Census. Projections for 1970-80 made on basis of steady continuation of current trends, on expected medical school enrollment and life tables. "Children" by definition includes all persons under 15 years of age.

THE CHILD HEALTH MANPOWER CRISIS

As public pressure, public policy, and national legislation remove the economic selection factor for access to child health services, and extend availability of such services to all sections of our child population, and as the number of children increase from the 60,000,000 of today to the possible 75,000,000 of 1980, the disparity between national goals to provide health care services and available manpower to provide such services will become critical.

The ratio of medical practitioners caring for children (pediatricians and general practitioners) to the child population under the age of 15 years fell from 336 per 100,000 in 1940 to 146 per 100,000 in 1960. Similar calculations for the past four decades and projections for 1970 and 1980 are shown in the following table (Time-Motion Study of Practicing Pediatricians, Bergman, Dassel, and Wedgwood. *Pediatrics*, 38:254, 1966).

While the numbers are approximations, the orders of magnitude are probably correct. The suggested fivefold decrease in the ratio of medical practitioners caring for children to the child population in the four decades 1940-1980 is occurring at a time when our society has expressed a mandate for broader child health services to include all segments of the population.

Calculated estimates of manpower needs to provide these services are extraordinarily revealing. In 1980 there will be approximately 75 million children in the United States. To maintain the 1960 ratio of 1:685 for physicians car-

ing for children to the number of children in the population, we will need by 1980 about 110,000 physicians to provide these children's health services.

General practitioners as a rule do not see as many children as pediatricians, but are available as a medical resource, and are therefore included in child health manpower statistics. In addition, while 74,000 such practitioners are identified in these calculations, in 1966 the American Academy of General Practice listed only 29,000 members, and reported that almost half were over 50 years of age, and had therefore a limited number of years for future active professional function.

By 1980 the attrition of general practitioners, if current trends continue, will have reduced their number to less than 35,000. Again, if current trends continue, the number of practicing pediatricians will have increased to only about 16,000. There will then, with current trends by 1980, be possibly 51,000 physicians to provide services requiring 110,000 physicians by present standards. This represents an enormous manpower gap. From the time of high school graduation it currently takes up to 13 years to train a pediatrician. The new pediatricians for 1980 are now in college; in view of the lag period, attention to this manpower crisis is urgently needed.

To close the manpower gap, maintaining the present physician child ratio, by 1980 an additional 59,000 physicians would be needed to provide child health services. It is apparent that the present ratio, with the current techniques for provision of child health care is inadequate, and thus the number required for such health services would actually be significantly greater. It is in any case inconceivable that the majority of medical school graduates for the next 15 years could be recruited for this purpose, and even if they could the recruitment would deplete other equally critical medical areas. Thus new techniques for the provision of health care must be developed and new types of child health personnel, to multiply the effectiveness of pediatricians must be evolved, to meet these health care needs.

Pediatric departments will have to become involved in such innovations. However, whatever the form of innovation, in the interim and in the future, greatly increased numbers of pediatricians and family doctors must be trained. The pediatric departments are concerned with their ability to meet this challenge. They may be unable, because of current lack of support, personnel and facilities to expand their training programs and extend their efforts in innovative and appropriate ways to meet the new demands of comprehensive community child health care.

THE CURRENT STATE OF PEDIATRIC DEPARTMENTS

It is difficult to estimate the quality of Pediatric Departments. Objective criteria have not been established and evaluation requires subjective value judgment.

It is our belief that the present serious weaknesses and problems of many Pediatric Departments are not adequately recognized. Of the nearly ninety current departments perhaps only one in ten has sufficient strength or flexibility to man new programs, to innovate creative techniques for the provision of extended and expanded training in comprehensive community child health care. While several other departments are sufficiently strong for existing training purposes, without additional support they would have serious difficulty in expanding their training potential significantly at this time. Many departments, perhaps even one-half, currently have serious weaknesses. Several of these are so weak as to be marginally viable, and a few by organization, structure and function are in essence still functioning in the manner described by Flexner in 1910 (A. Flexner; Medical Education in the United States and Canada. Carnegie Foundation, Bulletin No. 4, 1910).

In the report presented from the study of the Pediatric Research Education and Practice Committee (A study of pediatric residency training and pediatric research projects. Joint Committee on Pediatric Research, Education and Practice; 1965), using research as an index of quality, it was found that half of the Departments of Pediatrics at the present time had less than ten identifiable research projects (many had less than three) contrasted with the strongest five to ten per cent who had more than three times as many. The disparity

between the strong and the weak was striking. Alternatively, using the criteria of research expenditure, over half of the Pediatric Departments reporting had research expenditures of less than \$200,000 annually (range: \$3,000 to \$200,000), contrasting strongly with the upper ten per cent, each of whom had annual expenditures of over \$1,000,000 annually.

To gain information needed to evaluate the manpower problem for comprehensive community child health care services and the academic resources available for training such manpower, an inventory of Pediatric Departments is currently being carried out by the Association. Preliminary data have substantiated the preceding value judgments. There are at this time two pediatric departments with no full-time faculty. Ten per cent have less than five faculty members; one-third have less than ten. The funds provided to departments for medical education by their medical schools are severely limited. Ten per cent have less than \$50,000 annually to cover all costs of department function; faculty salaries, administrative support, equipment, supplies and in some instances even to some extent stipends for trainees. Forty per cent have less than \$100,000 annually. Such lack of support for medical education forces many departments to obtain support from funds for research and service (including private practice), diminishing emphasis on clinical teaching. Indeed, in almost one-third of the departments less than fifteen per cent of the funds are derived from the medical school, even though total expenditures may be large. While research is vital in this field, and contributes by new knowledge to improved teaching and improved health care, similar support for education is also vital so that clinical teaching may have equivalent emphasis, and clinical training may be an equally attractive field of medicine.

The situation is thus very serious and should not be underestimated. Several departments are in imminent danger. The weak departments cannot recruit faculty to strengthen their function because they lack funds, space, and academic atmosphere. Strong departments with well-functioning academic and research training programs find it difficult to assist the weak departments in their recruitment process. Young faculty and trainees within strong departments, having been brought up to work in an academic atmosphere with emphasis on teaching and research are unwilling to accept positions in weak departments where the emphasis, in many cases, continues to be primarily on support of the faculty through private practice, and where facilities for proper academic function are lacking. Academic mobility is thus jeopardized and regional redistribution of training potential made difficult and, in many cases, impossible.

The situation is made even more acute by the recent legislation in the areas of heart, cancer, and stroke, by regional medical programs for these particular diseases, and by the implementation of Medicare for the aged. These new programs are pre-empting space and money with Schools of Medicine, including crucial matching and construction money. Emphasis is thus being directed away from the areas of child health.

RECOMMENDATIONS FOR ACTION

The situation is sufficiently critical at this time to necessitate major interim measures pending outcome of studies of the manpower crisis.

If we are to preserve the training potential of this group of Pediatric units who currently train the vast majority of Pediatricians, and are deeply involved in many instances, in the training of varieties of allied health professions for children's services, we need to find some way to provide immediate support that will strengthen them, and also stimulate the Medical Schools in which the departments exist to back their development more strongly. An analogy to the position of psychiatry in 1946 exists, and possibly action similar to that provided through the National Mental Health Act needs to be considered.

The Association in 1967 approved unanimously several recommendations to accomplish these goals. The recommendations we believe can be implemented through existing legislation, either by amendment making minor language changes or by appropriate funding under existing authorization. The recommendations which have been spelled out in considerable detail and for which appropriate funding in two instances has been reasonably estimated can be summarized as follows:

1. To strengthen and expand clinical training programs, that on application, funds be directly allocated to Medical Schools for Departments of Pediatrics, for the purposes for strengthening and expanding clinical training programs for the provision of personnel for comprehensive community child health care. Such funding should in part be on a formula matching basis with Medical School funding for Pediatric faculty.

A reasonable probable cost estimate for such a program to have significant effect initially would be approximately \$7,500,000 annually.

2. To increase numbers and quality of Pediatricians and emphasize those areas of additional training needed for the provision of comprehensive community child health care, including especially the social sciences, that upon application, funds be directly allocated to Medical Schools, for Departments of Pediatrics to strengthen and support residency training.

Using calculations based on providing an incentive subsidy to existing residency stipends, and on increasing the number of pediatricians being trained by about 25 per cent, a reasonable probable cost estimate for such a program initially would be approximately \$5,000,000 annually.

3. To provide the necessary facilities for teaching and research innovative techniques for the provision of coordinated community child health care, project grants be made available to assist in meeting construction costs. Such funding should be available for both the needed clinical service facilities and the necessary associated biological, medical, behavioral and social research facilities which may result in increased effectiveness and efficiency in the provision of health care for our Nation's children.

The unavoidable lag time involved in application for construction funds, architectural planning, and completion of construction makes it probable that consideration of the provision of construction funds for the purpose of developing units for training in comprehensive community child health care be considered in the very near future. Such considerations should include recognition of the difficulties faced by Pediatric Departments in obtaining matching funds. It is probable that most institutions will have used such matching funds for other purposes, and that by the time comprehensive community child health care programs are established, matching funds for Pediatric Departments may very well be essentially non-available for this purpose.

We believe that these three recommendations for action are amply justified by the current critical child health manpower shortage and the present urgent public need.

Sincerely,

RALPH J. WEDGWOOD, M.D.,

President, Association of Medical School Pediatric Department Chairmen.

ASSOCIATION OF MEDICAL SCHOOL PEDIATRIC DEPARTMENT CHAIRMEN

(Founded 1961 ; Formally organized 1964)

Officers :

President, Ralph J. Wedgwood, M.D., Seattle, Washington.

President-Elect, C. Henry Kempe, M.D., Denver, Colorado.

Secretary, Robert J. Haggerty, M.D., 260 Crittenden Boulevard, Rochester, New York 14620.

Membership :

The Chairman or Acting-Chairman or Academic Administrative Head of the Department of Pediatrics of each accredited medical school of the United States (see list below).

Purpose :

The purpose of this organization is to foster education and research in the field of child health and human development.

MEMBERSHIP LIST

- Dr. John A. Anderson
Univ. of Minnesota
Dr. Henry L. Barnett
Yeshiva Univ., N.Y.C.
Dr. B. E. Batson
Univ. of Mississippi
Dr. Franklin C. Behrle
New Jersey Col. of Med.
Dr. Herschel P. Bentley, Jr.
Med. Col. of Alabama
Dr. Russell J. Blattner
Baylor Univ., Texas
Dr. Richard W. Blumberg
Emory Univ., Georgia
Dr. Alfred M. Bongiovanni
Univ. of Pennsylvania
Dr. Philip L. Calcagno
Georgetown Univ., D.C.
Dr. Robert F. Chinnock
Loma Linda Univ., Calif.
Dr. Amos Christie
Vanderbilt Univ., Tennessee
Dr. Charles D. Cook
Yale Univ., Connecticut
Dr. Robert E. Cooke
Johns Hopkins Univ., Md.
Dr. Edward P. Crump
Meharry Med. Col., Tennessee
Dr. Edward C. Curnen, Jr.
Columbia Univ., New York
Dr. C. William Daeschner, Jr.
Univ. of Texas
Dr. Floyd W. Denny, Jr.
Univ. of North Carolina
Dr. Albert Dorfman
Univ. of Chicago
Dr. Donal Dunphy
State Univ. of Iowa
Dr. Heinz Eichenwald
S.W. Med. Sch., Texas
Dr. Frank Falkner
Univ. of Louisville
Dr. Carl C. Fischer
Hahnemann Med. Col., Penn.
Dr. Arthur N. Fleming
Stritch Sch. of Med., Ill.
Dr. Richard E. L. Fowler
Louisiana State Univ.
Dr. Sydney S. Gellis
Tufts Univ., Massachusetts
Dr. Robert Kugel
Univ. of Nebraska
Dr. Philip Dodge
Washington Univ., Missouri
Dr. Bruce Graham
Ohio State Univ.
Dr. Melvin Grumbach
Univ. of California
Dr. Robert Haggerty
Univ. of Rochester, N.Y.
Dr. Jerome S. Harris
Duke Univ., N. Carolina
Dr. W. Ray Hepner
Univ. of Maryland
Dr. Gerald H. Holman
Med. Col. of Georgia
Dr. William A. Howard
Geo. Washington Univ., D.C.
Dr. Horace Hodes
Mt. Sinai Hosp. New York
Dr. Doris Howell
Woman's Med. Col. of Penna.
Dr. James G. Hughes
Univ. of Tennessee
Dr. Robert L. Jackson
Univ. of Missouri
Dr. Charles A. Janeway
Harvard Med. Schl., Mass.
Dr. Robert Brent
Jefferson Med. Col. of Phila.
Dr. Weston M. Kelsey
Bowman Gray Sch. of Med., N.C.
Dr. C. Henry Kempe
Univ. of Colorado
Dr. Horace M. Gezon
Boston Univ., Massachusetts
Dr. William G. Klingberg
West Virginia Univ.
Dr. Norman Kretchmer
Stanford Univ., Calif.
Dr. Saul Krugman
New York Univ.
M. Eugene Lahey, M.D.
Univ. of Utah
Dr. Jonathan T. Lanman
State Univ. of N.Y., Brooklyn
Dr. William E. Laupus
Med. Col. of Virginia
Dr. Robert B. Lawson
Northwestern Univ., Ill.
Dr. Charles C. Lobeck
Univ. of Wisconsin
Dr. Wallace McCrory
Cornell Univ., New York
Dr. Arthur E. McElfresh
Saint Louis Univ., Missouri
Dr. Robert J. McKay, Jr.
Univ. of Vermont
Dr. Donald N. Medearis, Jr.
Univ. of Pittsburgh, Penna.
Dr. Lyman T. Meiks
Indiana Univ.
Dr. Jack Metcalf
The Chicago Med. Schl., Ill.
Dr. Herbert C. Miller
Univ. of Kansas
Dr. John R. Mitchell
Creighton Univ., Nebraska
Dr. Thomas Nelson
California Col. of Med., L.A.
Dr. Edward A. Mortimer
Univ. of New Mexico
Dr. William Nyhan
Univ. of Miami, Florida
Dr. Richard W. Olmsted
Univ. of Oregon
Dr. Theodore C. Panos
Univ. of Arkansas

Dr. Paul Patterson
Albany Med. Col., New York
Dr. Milton Westphal
Med. Col. of S. Carolina
Dr. J. Cyril Peterson
Marquette Univ., Wisconsin
Dr. Norman C. Woody
Tulane Univ., Louisiana
Dr. Edward L. Pratt
Univ. of Cincinnati, Ohio
Dr. Sterling D. Garrard
State Univ. of N.Y., Syracuse
Dr. Harris D. Riley, Jr.
Univ. of Oklahoma
Dr. Mitchell Rubin
State Univ. of N.Y., Buffalo
Dr. Irving Schulman
Univ. of Illinois
Dr. Roland B. Scott
Howard Univ., Wn., D.C.
Dr. Louis B. Silverman
Univ. of North Dakota
Dr. Richard T. Smith
Univ. of Florida
Dr. W. F. Stanage
State Univ. of S. Dakota

Dr. Nathan B. Talbot
Massachusetts Gen. Hosp.
Dr. William Thurman
Univ. of Virginia
Dr. Arthur J. Moss
Univ. of Calif., L.A.
Dr. Victor C. Vaughan III
Temple Univ., Pennsylvania
Dr. William M. Wallace
Western Res. Univ., Ohio
Dr. Robert Ward
Children's Hosp., L.A., Cal.
Dr. Edward Wasserman
New York Med. Col., N.Y.
Dr. Ralph J. Wedgwood
Univ. of Washington
Dr. Warren Wheeler
Univ. of Kentucky
Dr. Paul V. Woolley, Jr.
Wayne State Univ., Michigan
Dr. James L. Wilson
Univ. of Michigan
Dr. Paul Wehrle
L.A. County Gen. Hospl., Cal.

* * *

AMERICAN ACADEMY OF PEDIATRICS,
Evanston, Ill., March 7, 1967.

RALPH J. WEDGWOOD, M.D.,
*University of Washington School of Medicine,
Seattle, Washington 98105*
ROBERT J. HAGGERTY, M.D.,
*University of Rochester Medical School,
Rochester, N.Y. 14620*

DEAR DRs. WEDGWOOD AND HAGGERTY: The American Academy of Pediatrics hereby designates you as the official representatives of the Academy for purposes of testifying before the Ways and Means Committee relative to legislation concerned with various aspects of child health.

The American Academy of Pediatrics has previously stated its concern regarding the rapidly increasing child population in the United States and the inability of our present system to provide a sufficient number of physicians and others adequately trained in pediatrics and child health to provide the desired and needed health services to this vast number of children. When these children are old enough to reproduce, the percentage of children in our population will be even greater.

In an attempt to meet these urgent health needs of our children, the Academy urges that:

(1) A study of existing child health programs be made to determine possible conflicts, overlapping or deficiencies in the present programs. Child health programs are presently under a great many different governmental agencies, and communication and coordination between these agencies is often not the best. The purpose of such a study would be to improve and coordinate existing and future child health programs in the hope that more efficient and effective services be provided.

(2) That programs be developed to encourage young people to enter pediatrics and child health fields. The many years required in the study of medicine and the specialization afterwards, discourage many interested people from entering pediatrics and child health fields. A program of fellowship support for post-doctoral training programs in pediatrics and child health would enable many to enter these fields that otherwise might not.

The subsidization of fellowship programs in psychiatry has been effective in bringing about a large increase in the number of physicians that went into psychiatry as a life work, so it is likely that a similar program for pediatrics would be helpful.

(3) Support for pediatrics departments, and especially for the teaching of clinical pediatrics, preventive medicine, community medicine and mental health, should be provided. In recent years, there has been considerable support to medical schools and hospitals for the development of research and the training of investigators. The support of research is most important but it is also important to make the provision of health services an attractive field of medicine. If the health services required by our population are to be provided, people must be encouraged to enter this field. Professors and instructors of clinical pediatrics, child health and community medicine should be supported in the same way that investigators are supported, and they should be made to be important in the faculties of the medical schools. An increase in prestige of the clinical and service departments would attract students and trainees to these services and should increase greatly the ability of our schools to produce health workers to take care of our people.

Likewise, support for the building of suitable facilities in medical schools and hospitals for the provision of medical care, health services and community health programs should be provided. Without these facilities, it would be almost impossible to increase interest in the provision of health services.

(4) It also appears rather obvious that in the foreseeable future the supply of physicians will not be adequate to meet the health needs of the population or to provide the services that have already been promised.

The need to develop other ways of providing health services is obvious. Support is urged for studies, demonstration projects and experimentation with different ways of providing health care and the training of new kinds of health workers to assist those we have, including studies to evaluate the new procedures and personnel.

Without experimentation in the rendering of services in new systems and/or with new kinds of health workers, an increase in efficiency of providing health care cannot be expected.

There are many special health problems of children about which the Academy is concerned, such as infant mortality, mental retardation, the prevention of infections, behavioral disorders and juvenile delinquency, to name a few, but it is illogical to talk about these problems without first solving the number one problem of producing more physicians, more pediatricians, and more child health workers to become involved in the solution of all other health problems.

If we can be of any assistance in any way, please do not hesitate to let us know.

Sincerely yours,

E. H. CHRISTOPHERSON, M.D.,
Executive Director.

THE AMERICAN ACADEMY OF PEDIATRICS

The American Academy of Pediatrics is a national organization of Board-certified pediatricians numbering 9,600 members.

Founded in 1930, the primary purpose of the Academy is to improve the health and welfare of children. To do this, the Academy fosters and stimulates interest in pediatrics, and correlates all aspects of work involved in the care of children.

It strives to maintain the highest possible standards for pediatric education in medical schools; pediatric care in hospitals; pediatric practice; and pediatric research.

The Academy perpetuates the history and best traditions of pediatric practice and ethics, maintains the dignity and efficiency of pediatric practice in relation to public welfare, and encourages contributions to and publication of medical and scientific literature pertaining to pediatrics. None of these objectives is pursued for profit.

The Academy enjoys reciprocal and friendly relations with all professional and lay organizations interested in the health and protection of children. This is accomplished through national, district, and state committees and liaison representatives.

National and regional scientific meetings are held, research and clinical investigation are encouraged, and publications of worthy studies are facilitated.

The Academy makes constant observations on conditions and progress in all fields of activities pertaining to children. Its various committees furnish competent, authoritative professional aid and guidance wherever these are wanted.

The Academy further seeks to:

- Define pediatrics as a medical specialty.
- Stimulate interest in pediatrics among premedical and medical students.
- Expand and improve postgraduate education.
- Stimulate the pediatrician to serve as a community leader.
- Improve regular, planned pediatric health services in the Western Hemisphere.

- Reduce infant mortality.
- Increase child health facilities.
- Reduce childhood accidents.
- Create better understanding of emotional needs of children.
- Promote prevention of disease by immunization and other means.
- Improve the quality of school health services.
- Translate Academy reports and programs into useful information for physicians and the public.
- Encourage a specific examination in pediatrics as part of all state medical licensing examinations.

The American Academy of Pediatrics is incorporated under the laws of the State of Illinois as a non-profit educational organization.

The officers are:

William S. Anderson, M.D., President, Washington, D.C. Clinical Professor of Pediatrics at George Washington University School of Medicine.

George B. Logan, M.D., President-elect, The Mayo Clinic, Rochester, Minnesota. Professor of Pediatrics, University of Minnesota School of Medicine.

Elinor H. Christopherson, M.D., Executive Director, 1801 Hinman Avenue, Evanston, Illinois.

Robert G. Frazier, M.D., Secretary, 1801 Hinman Avenue, Evanston, Illinois.

The Academy presents scientific programs, seminars, postgraduate courses, and publishes a monthly scientific journal named Pediatrics.

The Academy conducts studies and surveys of medical pediatric education, problems of providing health services, the training of pediatricians and the continuing education of pediatricians.

There are 35 active committees that develop standards for pediatric care and child health services which are published and distributed to all those interested in child health.

The Academy cooperates on a formal basis with 29 other organizations concerned with the health of children. These organizations range from professional societies to welfare, educational and voluntary private groups. A close liaison is maintained with official Federal and State health departments.

AMERICAN PEDIATRIC SOCIETY

Purpose.—To bring together men and women for the advancement of the study of children and their diseases, for the prevention of illness and the promotion of health in childhood, for the promotion of pediatric education and research, and to honor those who, by their contributions to pediatrics, have aided in its advancement.

Membership.—By election. Members are generally senior academicians in pediatrics: The age limit for active members being 68 years. Currently there are approximately 300 active members.

Officers.—President, Harry H. Gordon, New York City; Vice President, Alan Ross, Montreal; Secretary, Charles D. Cook, Yale University School of Medicine, Department of Pediatrics, 333 Cedar Street, New Haven, Connecticut 06520.

SOCIETY FOR PEDIATRIC RESEARCH

Purpose.—To foster pediatric investigation and to provide an opportunity for younger men to present their work.

Membership.—By election. Membership is restricted to individuals actively involved in investigation and who are under the age of 45 years.

Current membership is approximately 600 individuals.

Officers.—President, Irving Schulman, Chicago; Vice President, Alfred M. Bongiovanni, Philadelphia; Secretary, William B. Weil, Jr., University of Florida, Department of Pediatrics, Gainesville, Florida.

The CHAIRMAN. Dr. Wedgwood, we thank you, sir, for your very fine statement. Again, we appreciate your coordinating the views of the groups you represent into one statement.

Any questions of Dr. Wedgwood?

Mr. ULLMAN. Mr. Chairman.

The CHAIRMAN. Mr. Ullman.

Mr. ULLMAN. We appreciate your appearance before this committee. You come in very distinguished company with the Congressman from Seattle.

Could you give me just some general estimate as to how far H.R. 5710 goes toward answering your recommendations?

Dr. WEDGWOOD. The funding within section 305, Mr. Ullman, if appropriately interpreted by the recipients of the additional \$3 million that would go into this program would initiate the needed support for clinical residency training within the departments of pediatrics.

Mr. ULLMAN. Are you saying that they all could be accomplished within the framework of this legislation?

Dr. WEDGWOOD. No, sir. Only our recommendation No. 2 on page A-7 would be accomplished by this specific bill.

Mr. ULLMAN. Would be accomplished?

Dr. WEDGWOOD. Yes, sir.

Mr. ULLMAN. Are you saying that the others could be accomplished in this legislation by additional language?

Dr. WEDGWOOD. I believe they could be, Mr. Ullman. I think that there may be legislation already on the books that would accomplish recommendation No. 1. It is out of my field, but I would suspect that the authorization for the National Institute of Child Health and Human Development might with appropriate interpretation and direction and funding provide the solution to recommendation No. 1.

Mr. ULLMAN. Thank you.

Dr. WEDGWOOD. The construction funds are not apparent in any bill or legislation that I know of at the present time.

(The following letter was received by the committee:)

UNIVERSITY OF WASHINGTON,
SCHOOL OF MEDICINE, DEPARTMENT OF PEDIATRICS,
Seattle, Wash., March 23, 1967.

Hon. AL ULLMAN,
House of Representatives,
Washington, D.C.

MY DEAR MR. ULLMAN: I greatly appreciated the opportunity of testifying before the House Ways and Means Committee concerning child health manpower and H.R. 5710. I was particularly grateful to you for your interest and most pertinent questions.

You asked at that time whether H.R. 5710 would accomplish all the recommendations, while that bill will, through Section 305, begin to provide some support for manpower training in pediatrics, it does not accomplish all of the needed objectives.

I thought therefor that it might be of assistance to you if I were to amplify my answer to your question in writing, with some specific comments on possible needs for legislation and legislative interpretation.

Recommendation No. 1 (p A-7):

"... To strengthen and expand clinical training programs, that on application, funds be directly allocated to Medical Schools for Departments of Pediatrics, for the purposes of strengthening and expanding clinical training programs for the provision of personnel for comprehensive community child health care. Such funding should in part be on a formula matching basis with Medical School funding for Pediatric faculty.

"A reasonable probable cost estimate for such a program to have significant effect initially would be approximately \$7,500,000 annually. . . ."

It is my understanding that the wording of the legislation which established the National Institute of Child Health and Human Development (Public Law 87-838) could be interpreted to allow such authorization. If this is indeed the case, no additional legislation or language would be necessary. However, it would probably be necessary to give the appropriate instruction with necessary funding, to implement this resolution. A major effect could be obtained with relatively minor budgetary allocation.

Recommendation No. 2 (p A-7) :

" . . . To increase numbers and quality of Pediatricians and emphasize those areas of additional training needed for the provision of comprehensive community child health care, including especially the social sciences, that upon application, funds be directly allocated to Medical Schools, for Departments of Pediatrics to strengthen and support residency training.

"Using calculations based on providing an incentive subsidy to existing residency stipends, and on increasing the number of pediatricians being trained by about 25 per cent, a reasonable probable cost estimate for such a program initially would be approximately \$5,000,000 annually. . . ."

This would in part be accomplished by Title III, Section 305, if appropriate instruction is provided to the agency receiving the funds. The \$3,000,000 allocated for the fiscal year ending June 30, 1968 would suffice to initiate the program, and subsequent funding under the language could be adjusted for realistic support on the basis of experience.

Recommendation No. 3 (p A-7) :

" . . . To provide the necessary facilities for teaching and research in innovative techniques for the provision of coordinated community child health care, project grants be made available to assist in meeting construction costs. Such funding should be available for both the needed clinical service facilities and the necessary associated biological, medical, behavioral and social research facilities which may result in increased effectiveness and efficiency in the provision of health care for our Nation's children. . . ."

This is probably the most difficult of the recommendations. The inventory of pediatric departments which is currently in process will, hopefully, provide some basis for the estimate of need, which in turn can be translated into an estimate of approximate cost. At the present moment there is no specific legislation which can accomplish this goal, and new legislation may be necessary.

On the other hand, it might be possible, through language change in PL 88-164 (Part A) to implement the recommendation in an indirect manner. PL 88-164, under Title I ("Mental Retardation Facilities Construction Act"), Part A contains authorization "*. . . to assist in meeting the costs of construction of facilities for research, or research and related purposes, relating to human development, whether biological, medical, social, or behavioral, which may assist in finding the causes, and means of prevention, of mental retardation, or in finding means of ameliorating the effects of mental retardation. . . .*" This authorization expires July 1, 1967. If the authorization were extended and the wording changed slightly—perhaps as follows: "*. . . to assist in meeting the cost of construction of facilities for research and training in coordinated health care of parents and children, and the associated necessary biological, medical, behavioral and social research, particularly that which may assist in finding the causes, means of prevention, correction or amelioration of handicapping conditions, including mental retardation. . . .*", this existing legislation might, with appropriate funding provide the urgently needed facilities for training in maternal and child care. The broadened language would allow diversification of types of professionals trained, innovation in health care techniques and the needed flexibility to find new answers to the critical maternal and child health manpower problem.

It is of interest that the instruction to the Surgeon General in Sec. 762(b) of PL 88-164 is broader in language than the authorization for appropriations.

I hope this information will be of interest to you.

I would be delighted to assist you in these considerations in any manner that I may,

With many thanks.

Sincerely,

RALPH J. WEDGWOOD, M.D.,
Professor and Chairman.

The CHAIRMAN. Mr. Betts.

Mr. BETTS. You mentioned, Doctor, mortality rates among infants. Is it increasing, or decreasing?

Dr. WEDGWOOD. Sir, it is relatively static for the last few years. I think that the difficulty is the disparity in various population groups.

For example, in my city we have infant mortality rates of over 60 per 1,000 in some sections and down below 10 in some of our suburban sections, a disparity of over fivefold. It is the delivery of health services to improve the infant mortality that I think is a disgrace. We know what to do but we are not able to carry out the job.

Does this answer your question?

Mr. BETTS. Yes. Would you give us a comparison of mortality rates in other developed countries.

Dr. WEDGWOOD. Yes, sir. Our infant mortality rate is below that of Sweden, the Netherlands, Denmark, Australia, England and Wales, New Zealand, and Switzerland. Indeed we have dropped in the international scale for infant mortality over the past 10 years from an enviable position to one which is not enviable at all.

Mr. BURKE. Will the gentleman yield there for one question?

Mr. BETTS. Yes.

Mr. BURKE. In the crowded tenement districts in this country, in cities like New York, Chicago, and Philadelphia to what extent have mortality rates changed? How do the figures compare in New York City, say in 1966 against 1960 or in Philadelphia or Boston?

Dr. WEDGWOOD. I can't answer that question, Mr. Burke, but I would be delighted to get the information and submit it to you.

Mr. BURKE. In your opinion is the mortality rate dropping in those cities, or is it increasing?

Dr. WEDGWOOD. The initiation of the maternal and infant care programs may just be beginning to have some effect, but prior to that time, no, I don't believe that there was a significant improvement.

Mr. BURKE. There has been no significant improvement during the last couple of years over 1960.

Dr. WEDGWOOD. No, sir.

Mr. BURKE. This in spite of all the money that is being poured into the cities on various programs. I know this may not affect the particular program you are talking about; but other programs.

Dr. WEDGWOOD. We lack the manpower, Mr. Burke, to implement these programs.

Mr. BURKE. Thank you. Thank you, Mr. Betts.

Mr. BETTS. Just a little bit of explanation. You say, we are below these other countries. You mean our infant mortality rate is higher?

Dr. WEDGWOOD. Yes, sir.

Mr. BETTS. I see.

Mr. COLLIER. That is on a per capita basis?

Dr. WEDGWOOD. That is figured on a rate basis per 1,000 live births, the number of infant deaths under the age of 1 year per 1,000 live births in our Nation. We are below those countries. The mortality rate is higher.

The CHAIRMAN. Mr. Collier.

Mr. COLLIER. Just to get these statistics you gave in perspective, you mentioned that our decrease in the mortality rate—I presume you mean for the past year—was 5 percent; is that correct?

Dr. WEDGWOOD. Over the 10 years 1954 through 1963, which were the only available figures to collate with other countries.

Mr. COLLIER. From 1954 to 1963 it was reduced by 5 percent. I believe you mentioned another figure which I can't find in the printed statement—it may be there—that in other countries it had been reduced over this same period by 25 percent?

Dr. WEDGWOOD. And higher, sir.

Mr. COLLIER. Yes. These percentages would be significant and perhaps they are, but I think to get them in perspective we would have to do so on the basis of determining what the per capita mortality rate was in these countries during this period and what the mortality rate was here because obviously if the mortality rate is much, much higher, the area to reduce it by a greater percentage is there, where if it is lower, a 5 percent, as you know, would be more significant than perhaps a comparison of the 5-percent and the 25-percent figure.

What was the incidence in these countries that you say reduced their mortality rate by 25 percent as compared to the per capita mortality rate for the same period in this country so we get these two figures in perspective.

Dr. WEDGWOOD. Sir, the mortality rate in 1954 for infants in the United States was 26.6 per 1,000 live births. In 1963 it was 25.2, a reduction of 1.4.

In another country, for example, the Netherlands, in 1954 the mortality rate was below that of the United States, 22.6, and yet in spite of that over the 10-year period they reduced their mortality rate by 1963 to 15.8, a reduction of 30 percent.

Another country with an equivalent type of figure, Denmark, in 1954 had an infant mortality rate of 26.9, much akin to ours in that year, in 1963 it had been reduced to 19.1, a reduction of 29 percent.

Well, I could give the remainder with about the same type of figures, sir.

The CHAIRMAN. For the record why do we not put the entire list that that you have before you in the record?

Dr. WEDGWOOD. I would be delighted to submit it.

The CHAIRMAN. All right. Fine. Without objection.

Mr. COLLIER. His answer is all right.

The CHAIRMAN. I think it is well to have the entire list if there is no objection. Leave it with us, if you will.

Dr. WEDGWOOD. Yes, sir.

(The information referred to follows:)

TABLE 12.—*Infant mortality rates: Selected countries, 1954-63*

[Rates are deaths under 1 year]

Selected countries	Rates per 1,000 live births									
	1963	1962	1961	1960	1959	1958	1957	1956	1955	1954
Australia.....	19.5	20.4	19.5	20.2	21.5	20.5	21.4	21.7	22.0	22.5
Canada.....	26.3	27.6	27.2	27.3	28.4	30.2	30.9	31.9	31.3	31.9
Denmark.....	¹ 19.1	20.1	21.8	21.5	22.5	22.4	23.4	24.9	25.2	26.9
England and Wales.....	¹ 21.1	¹ 21.7	21.6	21.8	22.2	22.5	23.1	23.7	24.9	25.4
Finland.....	18.2	20.5	20.8	21.0	23.6	24.5	27.9	25.7	29.7	30.6
Netherlands.....	15.8	17.0	17.0	17.9	18.1	18.5	18.4	20.2	21.6	22.6
New Zealand.....	19.6	20.4	22.8	22.6	23.9	23.4	24.3	23.2	24.5	24.1
Norway.....		17.7	17.9	18.9	18.7	20.0	20.5	21.2	20.6	21.4
Sweden.....	15.4	15.4	15.8	16.6	16.6	15.9	17.8	17.3	17.4	18.7
Switzerland.....	20.5	21.2	21.0	21.1	22.2	22.2	22.9	25.8	26.5	27.2
United States.....	25.2	25.3	25.3	26.0	26.4	27.1	26.3	26.0	26.4	26.6

¹ Provisional.

Sources: For 1954-59, Statistical Office of the United Nations, *Demographic Yearbook*, 1963, New York: United Nations, 1964; for 1960-63, Statistical Office of the United Nations, *Demographic Yearbook*, 1964: New York, United Nations, 1965; National Center for Health Statistics, *Vital Statistics of the United States* 1963, Vol. II, Pt. A, Public Health Service, Washington, U.S. Government Printing Office, 1965.

From National Center for Health Statistics; Public Health Service Publication No. 1000-series 20-No. 3, September 1966.

United States; infant mortality rates, 1960-65

[Deaths per 1,000 live births]

1960.....	26.0	1963.....	25.2
1961.....	25.3	1964.....	24.8
1962.....	25.3	1965.....	24.8

From: Statistical abstract of the United States, 1966.

New York City: Infant mortality rates

Year:	Deaths per 1,000 live births		
	Total	White	Nonwhite
1960.....	26.0	20.3	42.4
1961.....	25.6	19.7	39.7
1962.....	27.3	21.1	43.3
1963.....	25.8	19.9	39.2
1964.....	26.8	20.1	41.0
1965.....	25.7	19.4	39.4

From: New York City Summary of Vital Statistics, 1966.

The CHAIRMAN. Any further questions?

Thank you again, Dr. Wedgwood, for coming to the Committee. We appreciate it very much.

Dr. WEDGWOOD. Thank you, Mr. Chairman.

Mr. ULLMAN. Mr. Chairman, I would like to ask permission at this point in the record to insert a letter received by me from Mr. Andrew F. Juras, administrator of the Oregon State Public Welfare Commission.

The CHAIRMAN. Without objection, Mr. Juras' letter will be made a part of the record.

(The letter referred to follows:)

STATE OF OREGON,
STATE PUBLIC WELFARE COMMISSION,
Salem, Oreg., March 10, 1967.

HON. AL ULLMAN,
*House of Representatives,
Washington, D.C.*

DEAR REPRESENTATIVE ULLMAN: The Oregon State Public Welfare Commission extremely concerned over the growing demands made upon it by communities throughout the state to provide more services to troubled children, both within and outside their own homes. Our child welfare caseload is increasing rapidly and the present method of financing public child welfare services makes it impossible to keep pace with the need.

Many people are unaware that the Federal Government has not financially supported to any great degree the respective state child welfare service programs. For example, the present budget under consideration by our Legislature for child welfare services is \$14,830,461 in state and county funds. This includes money for the payment of foster care, purchase of care from licensed voluntary agencies, and personnel services including training of child welfare staff. It is anticipated that under the present Federal Grant-in-Aid to Oregon, we will receive approximately \$930,000 for the biennium, or far less than 10% of the estimated expenditures for this period of time.

Congressman Burke has introduced House Resolution 1977 and the State Public Welfare Commission is unanimous in its support of this proposed legislation. We believe that an appropriation should be made available to be administered by the Children's Bureau in order to provide an open-end child welfare budget. Administrative matching in child welfare should be on the same basis as is the matching in public assistance administration.

Foster care payments should be matched by the Federal Government and these funds should be available on a case by case basis in accord with the open-end budget principle. Available funds is not a reasonable criterion for the determination of the level of services to be provided when children's needs are at stake; yet many states, including Oregon, have had to refuse foster care services because of lack of funds. Federal matching could be used to encourage states to establish more adequate foster care rates and to develop specialized foster homes for children with particular kinds of needs, such as special group family foster homes.

We concur with the other requirements of House Resolution 1977 which would require that states develop plans for extension of child welfare services satisfactory to the Secretary of Health, Education, and Welfare as a condition to receive Federal financial support. We believe that "special money or seed money" should be available to states to finance experimental services, which learning experience could be helpful to serve children and their families better. With the extreme shortage of trained personnel, we believe that Federal matching for training grants not only should be continued, but increased with the hope that the manpower shortage in this field can be reduced. House Resolution 1977 which would authorize Federal matching grants for all state child welfare services as well as 75% matching for salaries and training of child welfare personnel would be of great help to Oregon. It would mean that we could develop and provide a full range of child welfare services to help keep children in their own homes as well as to support them more adequately when necessary in foster care. Day care services and homemaker services are extremely limited in Oregon and passage of this Bill could help us develop these vital services throughout the state. The number of illegitimate births are increasing and more demands are being made upon adoption services and more staff is needed to find homes for many of the children who are now relinquished for adoption.

We are aware of the Administration proposals contained in the President's Special Message on Children and Youth of February 8, 1967, and which was introduced by Congressman Mills on February 20th known as "Social Security Amendments of 1967", House Resolution 5710. These proposals fall far short of the comprehensive child welfare plan envisioned in the Burke Bill, House Resolution 1977. House Resolution 5710, if passed, would provide only 75% Federal matching of public child welfare staff of the excessive state costs over the base year of 1966-67. This means that after June 30, 1968, states would be reimbursed for 75% of whatever additional state funds they expand in the future for

personnel and training. This kind of financial support would not assist us greatly in the development of a broad range of child welfare services as the financial support is too limiting and most of the costs would still have to be met through state and county funds.

We urge you to study these two proposals and hope you will find it possible to support the enactment of the Burke Bill.

Very truly yours,

ANDREW F. JURAS, *Administrator.*

(The following telegrams were received by the committee:)

BOSTON, MASS..

March 14, 1967.

HON. BARBER B. CONABLE,
The Ways and Means Committee,
House of Representatives, Washington, D.C.

Am in strong agreement with purposes of H.R. bill 5710 to develop new programs for child care. Doctor Wedgwood will testify March 16 in favor and I support his testimony. I hope you can support these most important amendments to improve child health.

ROBERT J. HAGGERTY, M.D.,
Professor and Chairman, Department of Pediatrics, University of Rochester
School of Medicine, Rochester, N.Y.

March 13, 1967.

Representative WILBUR MILLS,
U.S. House of Representatives, Washington, D.C.

The Council of the Society for Pediatric Research respectfully urges that you support those sections of H.R. 5710 which pertain to child health. The society has appointed Dr. Ralph Wedgwood to represent its views in testimony before your committee.

IRVING SCHULMAN, M.D., *President.*

March 13, 1967.

Representative WILBUR MILLS,
U.S. House of Representatives, Washington, D.C.

The American Pediatric Society urges support for those sections of H.R. 5710 which are pertinent to child health. Dr. Ralph Wedgwood has officially been designated to represent the views of this society.

HARRY H. GORDON, M.D., *President.*

The CHAIRMAN. Mr. Passett. Mr. Passett, if you will give us for the record your name, address, and capacity in which you appear, we will be glad to recognize you, sir, for the 10 minutes which has been requested.

STATEMENT OF BARRY PASSETT, DIRECTOR, NEW JERSEY COMMUNITY ACTION TRAINING INSTITUTE

Mr. PASSETT. Thank you, Mr. Chairman. My name is Barry A. Passett. I am director of the New Jersey Community Action Training Institute in Trenton, N.J.

The CHAIRMAN. You are recognized, sir.

Mr. PASSETT. Mr. Chairman, Congressmen on the committee, I am particularly grateful for the opportunity to testify on H.R. 5710 as it relates to training. I will refer you to my written statement which I request be submitted for the record.

The CHAIRMAN. Without objection the entire statement will be made a part of the record.

(The statement referred to follows:)

STATEMENT OF BARRY A. PASSETT, DIRECTOR, NEW JERSEY COMMUNITY ACTION TRAINING INSTITUTE

STATEMENT OF THE PROBLEM

Mr. Chairman, thank you for this opportunity to appear before the Committee to present my views on this innovative legislation.

The nation today is faced with a strange anomaly. The unemployment rate continues at 3.5% while manpower shortages exist and increase.

The sharply declining demand for unskilled labor in many areas of employment is reflected in the statistics, yet manpower needs increase in the ever-expanding areas of human services.

It is evident that one of the most important tasks to which we can assign the nation's resources at this time is the training or retraining of individuals for the purpose of restoring them to employability and preparing them for new careers.

The existing gap in trained personnel in the human services indicates a clear need for bold and innovative methods for achieving the ultimate ends of a fully productive and a fully served society.

H.R. 5710 is pregnant with the means to secure these ends.

H.R. 5710, TITLE III, SECTIONS 535 AND 306

Title III, Section 535, would authorize the appropriation of \$13,000,000 for the training of personnel for health care and related services for mothers and children. Section 306 would increase to \$18,000,000 the appropriation for grants to projects which would help research the need, effectiveness and feasibility of maximum utilization of health personnel with varying levels of training. Methods of training and the actual training of personnel would be included in this program.

The future physical well-being of the nation could be dependent upon the adoption and the effective implementation of these proposals.

The implementation and the ultimate effectiveness of this pilot project are the points to which I wish to address the Committee's attention.

The training of individuals to function as skilled personnel in the areas of human services—health, education and welfare—could provide, at once, the manpower which is vitally needed in these areas and a sharp reduction of the national unemployment rate.

The National Commission on Technology, Automation and Economic Progress estimated that there are 3.5 million potential sources of new jobs in six categories of public service, "where social needs are now inadequately met if . . . they are met at all."

The Commission recommended the expansion of public service employment into a permanent long-term program and the providing of opportunities for those who are unsuccessful in the competition for existing jobs.

The pilot projects proposed by H.R. 5710 could provide such opportunities. This proposed legislation seems to indicate a national awareness of the potentiality of new job sources.

The language of the legislation as now proposed, however, would limit the intent and purpose of the proposal. Section 535 would authorize the Secretary of Health, Education and Welfare to extend grants *only* to public or non-profit private institutions of *higher* learning for training personnel.

The staffs and facilities of the nation's colleges and universities are, in the main, already overtaxed in their efforts to provide the highly skilled professional needs of our society. In the State of New Jersey, for example, Rutgers the State University received 15,022 applications last year and was able to accommodate only 3,557 students. The traditional institutions of higher learning would have to be restructured before they could completely provide the facilities designed to reach those disadvantaged unemployed and underemployed whom these demonstration projects should be attempting to aid.

The urgency of the manpower needs for human services clearly indicates the importance of utilizing *all* available educational resources in a sustained frontal attack on this problem.

The New Jersey Community Action Training Institute is a private non-profit corporation working on the first statewide approach to community action. It is one of a series of training organizations brought into being under the impetus of the Economic Opportunity Act. It receives support from the Office of Economic Opportunity. It has provided training for more than 1,200 people involved in all phases of the New Jersey war against poverty since it was created in December, 1965.

The Institute has established a close working relationship with New Jersey state agencies operating in the areas of human services. We are an established training facility designed to provide the type of service and coordination which will be necessary if the proposals of Sections 535 and 306 are to be effectively implemented.

The current language of Section 535 would, however, bar our training facility and similar ones throughout the nation, from participation in the proposed projects.

The language of section 535 should be changed, therefore, to include *all* public or non-profit private *educational* institutions.

WHO WILL BE TRAINED AND FOR WHAT?

Section 306 would provide for "maximum use . . . of health personnel with varying levels of training". Congress is, it appears, attempting to solve the dual problems of the health needs of the nation's children and the economic needs of mothers who are without support. In other Titles and Sections of this legislation the Congress is also, wisely, establishing mechanisms for dealing with these problems.

The language of the bill does not, however, set forth a definition of the persons who would be eligible to receive such training. The war on poverty has stressed the need and the feasibility of opening new career opportunities to the disadvantaged.

The establishment of the Neighborhood Youth Corps has been one means to meet this end. During the first year of existence the Corps provided more than 500,000 public service jobs for disadvantaged youths in 1,446 private non-profit organizational projects.

The enactment of the Scheuer-Nelson Sub-professional Career Act is another forward thinking program aimed at training the unemployed to make them productive and useful members of society.

These programs are organized under the supervision of the Department of Labor. The coordination of these programs with the programs proposed by H.R. 5710 could represent a total attack on the joblessness and hopelessness of the disadvantaged. The administration of H.R. 5710 sections 353 and 306; by the Department of Labor might contribute to such coordination.

Job vacancy statistics do not bear out the seemingly common belief that work is available to the unemployed if they just know where or for what to look. There are recent indications, in fact, that there are few unfilled jobs relative to unemployment in unskilled and semi-skilled categories.

The unskilled disadvantaged need the development, not just of jobs but of new careers. The new careers concept calls for the development of *permanent* positions "incorporated into the matrix of the industry or agency" with latitude for limited advancement without the requirement of extensive additional training.

The opportunities available for such careers for the now unemployed and underemployed are evident in the findings of the joint research project of the U.S. Public Health Service and American Hospital Association "that the nation's 7,100 hospitals need 109,000 employees to fill existing vacancies and require an added 166,000 to improve the quality of medical care". An opportunity exists here to help the disadvantaged become useful and needed citizens. The value of such experience has been demonstrated by the Foster Grandparents program in which the know-how of the aged is utilized in helping children.

There is currently a severe shortage of personnel and facilities for the proper care of children. Cases of children left in the care of a blind woman, or kept in a dusty attic in overturned crib cages which were too small for most of them, have recently been cited. Mentally retarded children are kept in homes or

institutions where sufficient help is not available. Some children are not fed or bathed regularly because there are just not enough "hands" to go around.

The provisions of H.R. 5710 could eliminate such abuses. Mothers who are now on welfare can fill the needs of the nation in child care and health.

The pilot projects proposed by H.R. 5710 could provide the dual purpose of creating careers and training for the disadvantaged. The language of the bill should be specifically directed to this end.

In New Jersey alone, some 1,139,500 people are unemployed. This represents 5% of the work force in the State. There are 180,444 families existing on a below \$3,000 poverty level income.

These people could be helped to become useful and needed members of society. The Vocational Education Division of the State of New Jersey currently lists health occupations at the top of its list of priorities for training. New Jersey has experienced several successful work experience and training programs under Title V of the Economic Opportunity Act. An expansion of such programs, into the human services areas included in H.R. 5710, would provide the practical means for communities to obtain needed manpower and effectively combat poverty.

Mr. PASSETT. I make just a few comments in summary. I appear here to urge your support for elements of what is becoming a nationwide cause for movement, one which in the course of this generation may succeed the movement for medical care for the aged.

This committee played a vital role in the initial fulfillment of goals of that medical care movement. The new movement is called "New Careers for the Poor." Leaders in many phases of American life, labor, churches, industry, universities, the citizens crusade against poverty, are becoming involved in this movement. Simply stated, its purpose is to employ persons now unemployed or underemployed to fill human services career positions in areas where there are great needs and many vacancies.

The existing gap in trained personnel in the human services indicates a clear need for bold and innovative methods for achieving the ultimate ends of a fully productive and a fully served society, and H.R. 5710 is pregnant with the means to secure these ends.

Title III, section 535, would authorize the appropriation of \$13 million for the training of personnel for health care and related services for mothers and children. Section 306 would increase to \$18 million the appropriation for grants to projects which would help research the need, effectiveness and feasibility of maximum utilization of health personnel with varying level of training. Methods of training and the actual training of personnel would be included in this program. The implementation and the ultimate effectiveness of these pilot projects are the points to which I wish to address the committee's attention.

In my statement I point out that the language of the legislation that is now proposed might limit the intent and purpose of the proposal in that section 535 would authorize the Secretary of Health, Education, and Welfare to extend grants only to public or nonprofit private institutions of higher learning for training personnel.

The urgency of the manpower needs for human services clearly indicates the importance of utilizing all available educational resources in a sustained frontal attack on this problem.

The New Jersey Action Training Institute is a private nonprofit corporation which has provided training for more than 1,200 people involved in all phases of the New Jersey war against poverty since it was created just over a year ago.

The current language of section 535 would, however bar our training facility and similar ones throughout the Nation from participation in the proposed projects. The language of section 535 should be changed, therefore, to include all public or nonprofit private educational institutions.

I also note in my statement that there are useful nuclear programs now organized and operating under the supervision of the Department of Labor. The coordination of these programs with the programs proposed by H.R. 5710 could represent a total attack on the joblessness and hopelessness of the disadvantaged.

The administration of sections 533, and 306 by the Department of Labor might contribute to such coordination.

My main point is that the pilot projects proposed by H.R. 5710 could provide the dual purpose of creating careers and training for the disadvantaged. The language of the bill should be specifically directed to this end.

The unemployed and underemployed in New Jersey and other States throughout the Nation could be helped to become useful and needed members of society. I might note that the Vocational Education Division of the State of New Jersey currently lists health occupations at the top of its list of priorities for training. New Jersey has experienced several successful work-training programs under title V of the Economic Opportunity Act. An expansion of such programs into the human services areas included in H.R. 5710 would provide the practical means for communities to obtain needed manpower and effectively to combat poverty.

Thank you.

Mr. ULLMAN (presiding). I commend you, Mr. Passett, for the effective way in which you summarized your statement.

Are there any questions?

Mrs. GRIFFITHS. Yes.

Mr. ULLMAN. Mrs. Griffiths.

Mrs. GRIFFITHS. I would like to elicit a little support from Mr. Passett. If we would remove the earnings limitation on mothers who are drawing social security we could pick up 500,000 additional workers, and I would assume they would be very competent people.

Mr. PASSETT. We have been faced with that problem in New Jersey in a number of specific instances and it would be a marvelous way to cut through the red tape and the problems that get in the way of people who are trying to escape from poverty by working.

Mrs. GRIFFITHS. I am going to offer that amendment to this bill, so I hope that I can count on you to work on some of the rest of these people.

Mr. PASSETT. We will be glad to support you.

Mrs. GRIFFITH. Thank you.

Mr. ULLMAN. Are there any other questions? If not, we thank you very much, Mr. Passett, for your fine testimony.

Mr. PASSETT. Thank you very much, Mr. Chairman.

Mr. ULLMAN. The committee will now adjourn until 10 o'clock Monday morning.

(Whereupon, at 11:17 a.m., the committee adjourned to reconvene at 10 a.m., Monday, March 20, 1967.)

6/7/67

5763YF

PR

03-21-12 16207

507

XL

Group
3112

CMS LIBRARY



3 8095 00009531 1